DRUG ABUSE: QUAALUDES

HEARING

BEFORE THE

SUBCOMMITTEE ON INVESTIGATIONS AND GENERAL OVERSIGHT

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

EXAMINATION OF THE INCREASED USE OF CERTAIN DRUGS, FOCUSING ON QUAALUDES

MAY 13, 1982

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DRUG ABUSE: QUAALUDES

THURSDAY, MAY 13, 1982

U.S. SENATE,
SUBCOMMITTEE ON INVESTIGATIONS
AND GENERAL OVERSIGHT,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee convened, pursuant to notice, at 9:35 a.m., in room 5302, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senator Hawkins.

Staff present: Jay Howell, chief counsel, Terri Parker, counsel, Tim Jenkins, investigator, Lisa Demetree, professional staff member, and Connie Winter, staff assistant.

OPENING STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. Good morning. I would like to announce at the opening of this hearing that we have been notified there may be some votes this morning, but we will interrupt just long enough to make the vote, and then proceed immediately with the hearing.

Disco biscuits, the Love Drug, Vitamin Q, Sopors, 714's, Ludes—all of these are street names for the sedative known as methaqualone, or by its trade name, Quaalude. When it was first introduced in the United States in 1965, it was hailed in medical circles as a wonder sleeping pill, the first such aid with no hangover effect. Advertising such as this was mailed to all physicians, and at that time, methaqualone was subject only to a simple prescription requirement.

[Information supplied follows:]

MEDICAL WORLD NEWS
DECEMBER 31, 1965

ROHRER

William H. Rorer, Inc. announces

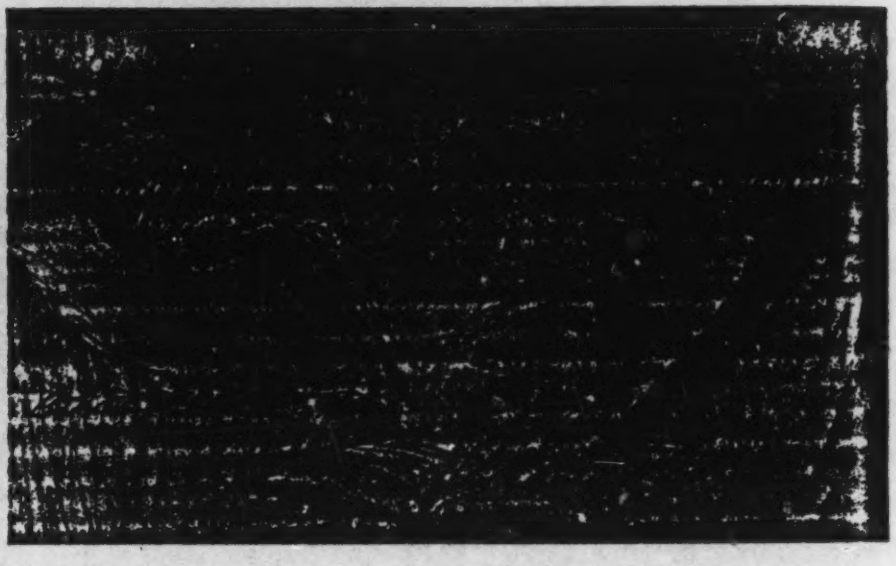
QUAALUDE™
(methaqualone)

For sleep—with special qualities of response, resumption and refreshment...*and* a record of successful clinical experience, both here and abroad, in which the drug has been used in hundreds of thousands of patients.

Please turn page for additional information...

a quality of response

acts promptly—usually induces sleep within 10 to 30 minutes



In 13 clinical studies, "good" to "excellent" responses were obtained in 73% of 1,120 patients. In addition:

- Quaalude provides 6 to 8 hours of satisfying sleep, even in chronic insomnias where other drugs have failed.
- Quaalude seldom causes preliminary excitation.
- If sleep is interrupted, resumption is prompt and spontaneous.
- Patients awaken alert, without hangover.

Quaalude™ (methaqualone)

ROBER

a quality of resumption

sleep can be interrupted, yet not disrupted

Quaalude is unique. It provides prompt and spontaneous resumption when, as so often happens, sleep is temporarily interrupted. Midnight telephone calls, nighttime storms, or other unusual situations may disturb the sleeper or, in the hospital, the patient's sleep may have to be interrupted for medication. With Quaalude, resumption of restful sleep is no longer a problem.

Quaalude™ (methaqualone)

ROHRER

Please turn page for additional information...

BEST COPY AVAILABLE

a quality of refreshment

"Patients awoke refreshed, without hangover, drowsiness, headache or other side effects...."[1]

Numerous investigators have been struck by the refreshing character of Quaalude-induced sleep. Ravina[2] has reported that awakening is pleasant and that patients are alert, immediately fit for physical or mental work.
Similar findings were reported by Asbell, who stated that patients fell asleep easily and awoke refreshed.[3] In addition, Quaalude provides:

- Rapid induction of sleep—10 to 30 minutes.
- Satisfying physiologic duration—6 to 8 hours.
- Reliable performance—works even in chronic insomnias where other drugs have failed.
- Prompt and spontaneous resumption when sleep is interrupted.

ROBER

Quaalude™ (methaqualone)

95-556 O—82—2

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When you prescribe Quaalude, you prescribe sleep...

- with a quality of response
- with a quality of resumption
- with a quality of refreshment

PRESCRIBING INFORMATION:

Formula: Each white, scored tablet contains 150 mg. methaqualone(2-methyl-3-o-tolyl-4(3H)-quinazolinone).

Actions: QUAALUDE (methaqualone) is a new non-barbiturate sedative-hypnotic which induces sleep usually within 10 to 30 minutes. Studies have shown effectiveness, even in chronic insomnias where other hypnotics have failed. It produces sleep which lasts 6 to 8 hours. Patients awaken easily, feeling refreshed and alert without evidence of "hangover". If sleep must be interrupted, resumption is prompt and spontaneous. The initial phase of excitation often encountered with other sedative-hypnotics is seldom a problem with QUAALUDE (methaqualone). The secondary pharmacological actions of QUAALUDE (methaqualone)—antitussive and antispasmodic—suggest that it may be especially useful in insomnias complicated by cough or gastrointestinal distress.

Numerous clinical studies on the sedative or hypnotic action of QUAALUDE (methaqualone) indicate a high order of efficacy. Good to excellent sedative or hypnotic results were obtained in 815 (73%) of 1,120 patients. Eight out of 10 double-blind investigations also confirm the clinical effectiveness of QUAALUDE (methaqualone).

Indications: To produce sleep. To provide daytime sedation.

Contraindications: QUAALUDE (methaqualone) is contraindicated in women who are or may become pregnant.

Warnings: The hypnotic dose should be taken only at bedtime, immediately before the patient retires, since QUAALUDE (methaqualone) may produce drowsiness within 10 to 20 minutes. If the patient becomes drowsy, but is prevented from falling asleep, he may experience a feeling of "pins and needles" in the hands, arms, feet and legs. The incidence of this side effect is very low and apparently of no significance. The patient on QUAALUDE (methaqualone) must be warned against driving a car or operating dangerous machinery while on the drug. Pending longer term clinical experience, QUAALUDE (methaqualone) should not be used continuously for periods exceeding three months.

Precautions: QUAALUDE (methaqualone) should be used with particular caution in anxiety states where evidence of impending depression or suicidal tendencies exist. QUAALUDE (methaqualone) may potentiate other drugs or itself be potentiated; adjust dosage with care when used with other drugs. It is not recommended for use with psychotropic drugs or other CNS depressants.

No cases of addiction have been reported; however, addiction potential has not been established. QUAALUDE (methaqualone) is metabolized in the liver and the usual precautions should be observed where impaired hepatic function exists. In many years of clinical use throughout the world, one case of aplastic anemia possibly related to methaqualone has been reported.

Adverse Reactions: Other side effects (mild and transient) have been encountered in less than 5 percent of all patients studied and have often proved statistically insignificant when compared with effects from placebo. Effects reported include headache, drowsiness, hangover, nausea, fatigue, epigastric discomfort, dizziness, dry mouth, emesis, torpor and exanthema. Transient paresthesia ("pins and needles") has been experienced by a few patients (see "warnings" section).

Usual Adult Dose: For sleep, one or two tablets (150-300 mg.) at bedtime. For sedation, one-half tablet (75 mg.) after each meal and at bedtime.

QUAALUDE (methaqualone) should not be used in children under 14 years of age. Dosage for aged, debilitated or highly agitated patients should be individualized in accordance with the judgment of the physician. The principle to be followed is to observe the response to small doses, and determine whether it is desirable to adjust the dosage.

Overdosage: Empty the stomach and supply general supportive measures. Pentylenetetrazol is suggested as an analeptic.

Supplied: Bottles of 100 and 500 tablets.

1. Newbauer, R.: Med. Times 91:61 (Jan.) 1963. 2. Ravina, A.: Presse Med. 67:891, 1959. 3. Asbell, N.: J. Am. Geriatrics Soc. 10:1032 (Dec.) 1962. Complete bibliography on QUAALUDE available on request.

Quaalude™ (methaqualone)

WILLIAM H. RORER, INC., FORT WASHINGTON, PA.

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Senator HAWKINS. The original U.S. manufacturers of Quaaludes could not have envisioned the crooked path the drug would follow. As illustrated by the nature and number of nicknames which have since surfaced, medicinal use of methaqualone has been completely lost in the shadow of uncontrolled and dangerous use.

Especially in the last 5 years, Quaaludes have become an enormously popular pleasure drug. It has become the second most heavily abused drug among teenagers and young adults, and approximately 90 percent of it now comes from illicit traffic. Drug Enforcement Administration international seizures of the substance have increased nearly a hundredfold since 1978. Also, while in 1978 more cocaine was seized than methaqualone, last year over 50 times as much methaqualone was intercepted. In 1981, the illegal traffic of Quaaludes was approximately a $2 billion business.

These figures do not incorporate the small but insidious pharmaceutical supply generated by physicians and profiteers who operate increasingly prevalent so-called stress clinics. Under the guise of affording legitimate medical service, these clinics provide a ready and expensive source of pharmaceutical Quaaludes, primarily for white collar young adults. The procedure is apparently quite simple: bring between $75 and $200 in cash; fill out a brief personal history form; claim personal or job problems; and trade the cash for a prescription of 30 to 45 Quaaludes. These scripts are often filled by one or two pharmacies working in concert with the clinic. The patient returns, and each month the procedure is repeated. Often, the entire visit takes as little as 5 or 10 minutes.

I emphasize that most physicians who prescript methaqualone do so responsibly and cautiously, and that the majority of the pharmacists that handle the drug closely guard its distribution. I find it especially troublesome, therefore, that a small fraction of this physician population can damage the entire profession by their disregard of the medical code of ethics. How tragic that those few physicians have so willingly prostituted their respected profession in the name of profit. More importantly, by fostering its use, they have lent an air of respectability and safety to a drug whose dangers are becoming increasingly apparent. In an effort to eliminate this segment of the methaqualone problem, I recently introduced legislation which in effect makes it illegal to possess, prescribe, or distribute the drug.

The results of the widespread use of both the counterfeit and domestically produced Quaaludes have been devastating. Emergency room mentions and methaqualone-related deaths have tripled since 1978. In 1981, at least 130 people lost their lives while under the influence of Quaaludes. While some of these were the result of accidental overdose, the great majority were from spontaneous suicides and fatal accidents resulting from a loss of motor control or judgment.

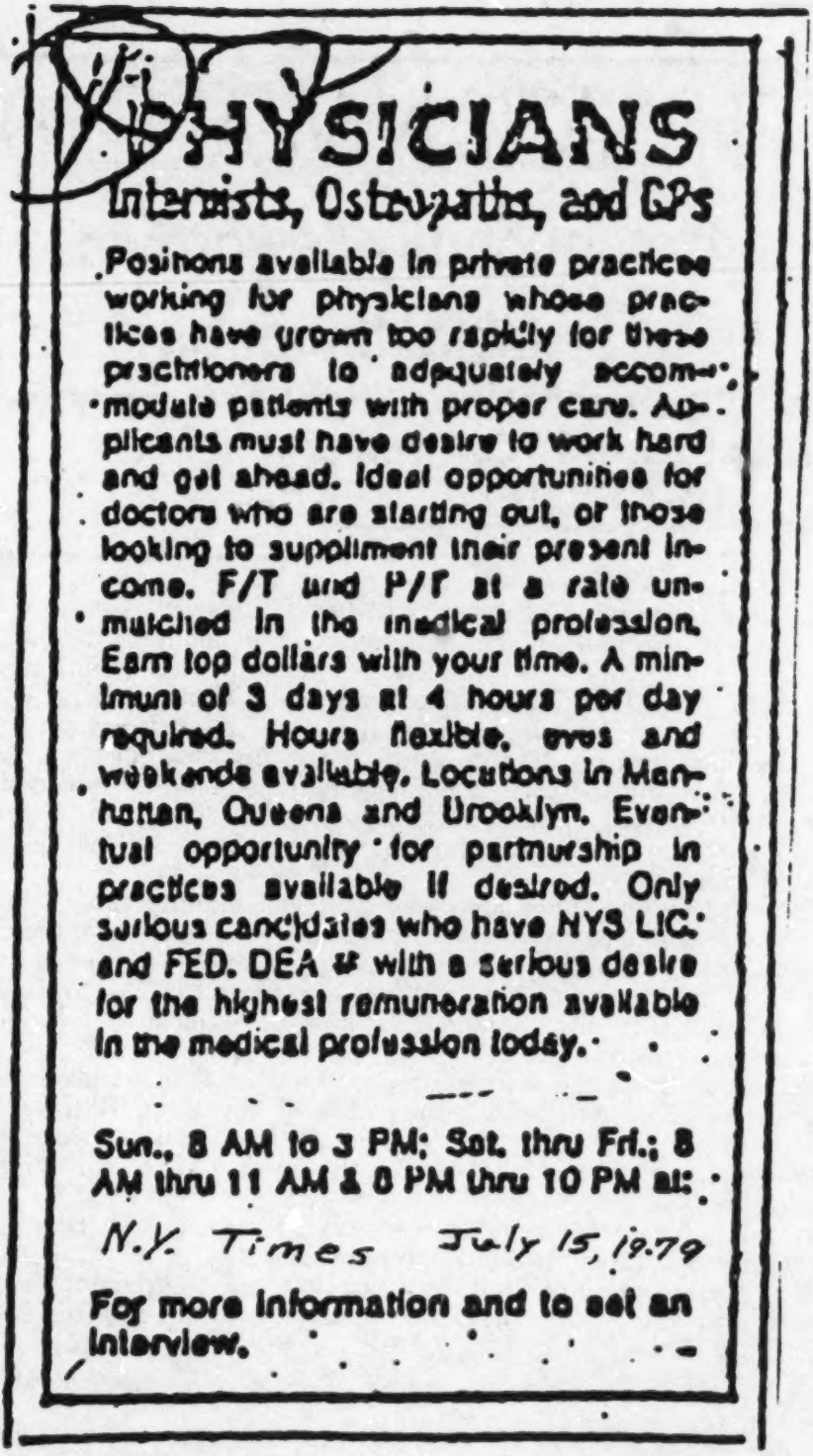
In Dade County, Fla., where the Quaalude problem is most acute, this pattern is especially evident. Of the 66 methaqualone-related deaths in 1981, only 6 were from unintentional overdose. The remainder were from traffic accidents, drownings, or suicide. Most of the individuals had taken the Quaaludes with alcohol, multiplying the debilitating effects.

As with any other illegal narcotic, the motive for dealing in Quaaludes is money. In the illicit market, a 25-kilogram drum of powder methaqualone, which would be about the size of an outdoor garbage container, sells for $750. About 83,000 tablets can be made out of that amount, each of which ultimately sell on the street for $3 to $5. On an investment of $750, therefore, the return is as high as $400,000.

The stress clinic business is also very profitable. By charging an average of $125 per visit, and spending an average of 15 or 20 minutes with each customer, operators can earn as much as $500,000 cash in a year. Physicians earn as much as $100,000 in a year of just part-time work.

These blown-up reproductions of classified advertisements which appeared in the New York Times, illustrate the great profits that physicians can make in stress clinics. The DEA has certified that those locations are indeed stress clinics. One part is especially compelling. It says, "Only serious candidates who have a serious desire for the highest remuneration available in the medical profession today should apply."

[Information supplied follows:]



PHYSICIANS

Internists, Osteopaths, and GPs

Positions available in private practices working for physicians whose practices have grown too rapidly for these practitioners to adequately accommodate patients with proper care. Applicants must have desire to work hard and get ahead. Ideal opportunities for doctors who are starting out, or those looking to supplement their present income. F/T and P/T at a rate unmatched in the medical profession. Earn top dollars with your time. A minimum of 3 days at 4 hours per day required. Hours flexible, eves and weekends available. Locations in Manhattan, Queens and Brooklyn. Eventual opportunity for partnership in practices available if desired. Only serious candidates who have NYS LIC. and FED. DEA # with a serious desire for the highest remuneration available in the medical profession today.

Sun., 8 AM to 3 PM; Sat. thru Fri.; 8 AM thru 11 AM & 8 PM thru 10 PM at:

N.Y. Times July 15, 1979

For more information and to set an interview.

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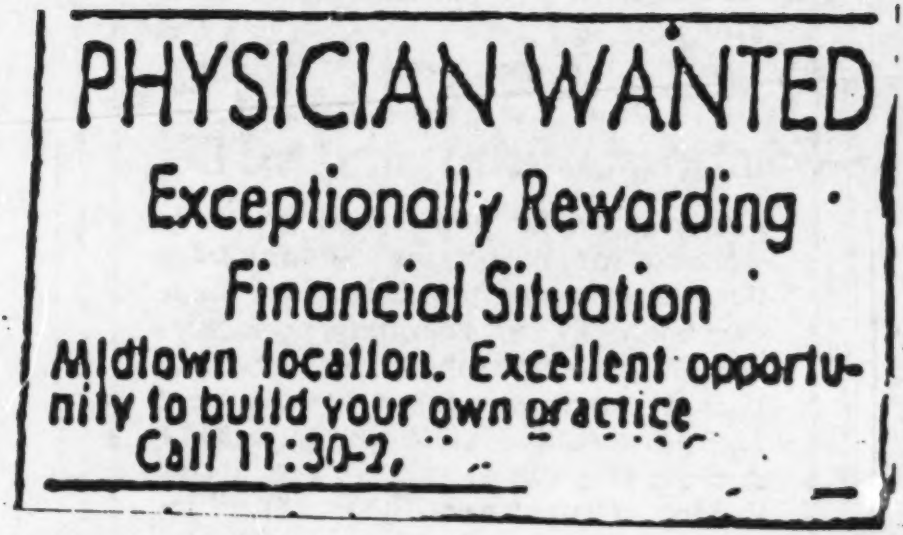
N.Y. TIMES Nov. 10, 1981



Senator HAWKINS. Today, we will hear from witnesses who will overview all segments of the methaqualone epidemic. Officials from the Drug Enforcement Administration and a law enforcement official from south Florida will detail the drug's flow from the source country to street level deals. We will also receive testimony regarding the operation of a stress clinic and difficulties encountered in bringing criminal or civil action against members of the medical community. Finally, the medical application of the drug, the reasons for its popularity, and the dangers associated with its use will be discussed.

The trade name Quaalude came from the manufacturer's intent to promote the drug as a "quiet interlude." As the risks of the drug became more apparent, it was renamed the "quiet epidemic." Today, it has come full circle. What started as the quiet interlude and became the quiet epidemic is now an explosive and deadly form of entertainment.

Seated in front of us today is our first panel of witnesses: Mr. Francis Mullen, Acting Administrator of the Drug Enforcement Administration, U.S. Department of Justice, and accompanying him, Mr. Eugene Haislip, also with the Drug Enforcement Administration.

I would like to welcome both of you here today and thank you for your cooperation with our subcommittee.

Mr. Mullen, I understand you have a full statement for the record, but you have a brief statement you would like to read at this time.

STATEMENT OF FRANCIS M. MULLEN, JR., ACTING ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION, DEPARTMENT OF JUSTICE, WASHINGTON, D.C., ACCOMPANIED BY EUGENE HAISLIP, DRUG ENFORCEMENT ADMINISTRATION

Mr. MULLEN. That is correct, Senator.

I appreciate the opportunity to appear before you to discuss a drug trafficking situation that has created a serious health problem in the United States. Before I go further, however, I want to comment that you have established the Senate Drug Enforcement Caucus. At last count, I know you had 32 Senators signed up—that may have increased since then—and it shows the interest on the part of the Senate. The caucus has been successful in focusing attention on the national drug problem, and I commend you for that initiative, Senator.

Senator HAWKINS. Thank you.

Mr. MULLEN. The problem we face with the drug methaqualone is indicative of how drug abuse and drug trafficking must be looked upon as global issues as well as domestic ones. The abuse of methaqualone, under such trade names as Quaalude and Sopor, was a growing problem in the early 1970's. At that time, abuse involved drugs that were legally produced in the United States. Stringent domestic controls on methaqualone put into effect by DEA, combined with adverse publicity concerning its abuse, brought about a temporary reduction in methaqualone abuse. The effect of this law, however, was only temporary. A steady increase in methaqualone abuse was observed from 1978 to 1980. Over those 3 years, methaqualone emergency room mentions rose 154 percent, and it was our most rapidly increasing drug abuse problem.

By 1981, adolescent reported methaqualone as the most popular drug of choice, next to marihuana. In the fall of 1980, DEA analysis of large seizures of methaqualone tablets by Federal, State, and local agencies established three facts. The tablets looked like legitimate Quaalude tablets, produced and distributed in the United States. In spite of their appearance, the tablets were in fact counterfeits. In spite of the counterfeit nature of the tablets, they contained methaqualone which had been legitimately produced somewhere. Further investigation made it clear that legitimate European pharmaceutical producers had unwittingly become sources of supply for the illicit distribution of methaqualone in the United States. In addition, a worldwide framework had developed of brokers, tableters, and smuggling organizations which were responsible for obtaining the methaqualone powder in Europe and bringing it ultimately to the shores of the United States.

Although there are numerous variations, the following represents a sketch of how approximately 120 tons of legitimate methaqualone powder was annually diverted into the illicit market. And we compare that 120 tons, Senator, with the less than 4 tons that is actually required for medical use in this country.

By using false letterheads, addresses, and perhaps forged importation documents, traffickers represent themselves to brokers in European free trade zones as legitimate purchasers of the drugs involved. The brokers in turn place the order with a major manufac-

turer and arrange for necessary shipping, usually without verifying the legitimacy of their customers.

The utilization of free trade zones complicates the tracking of these shipments, since these zones are intended to stimulate and promote trade and therefore offer exemptions from Government controls, such as recordkeeping and inspection regulations. The trail is often covered even more thoroughly by intentionally mislabeling the drug shipments as harmless chemicals or as fertilizer. From the free trade zone, the drug powder is shipped to clandestine tableting operations, primarily in Colombia, South America. It is here that the bulk powder is transformed into tablets, virtually identical to the legitimate product. Shipments of the counterfeit tablets are then transported by traditional smuggling routes using means such as aircraft and vessels to destinations in the United States.

In response to this problem, the Drug Enforcement Administration initiated a three-pronged program relating to the international diversion of methaqualone. The first involved diplomatic initiatives between the United States and foreign producing nations to curtail the manufacturing and exporting of methaqualone. In late 1980 and in early 1981, DEA with the support of the State Department, undertook a series of bilateral diplomatic initiatives with several nations, designed to increase cooperation and eliminate sources of diversion. The three major European producers of methaqualone imposed stringent import and export controls, thus voluntarily curtailing production. These nations were Hungary, Austria, and Germany. These actions removed at least 40 to 50 tons of methaqualone that would have been available for diversion to the United States illicit market and represented a significant step toward a long-range solution by eliminating availability at the source. Second, in conjunction with these efforts aimed at the supply of methaqualone, DEA has, with the support of the State Department, engaged in a diplomatic campaign through the international control bodies to reduce the flow of drugs into the United States. In the last 18 months, three significant resolutions have been adopted by the United Nations Commission on Narcotic Drugs, involving the diversion of legitimately manufactured drugs from international commerce. They involve calling for voluntary measures to prevent diversion, expanding the monitoring and reporting role of international drug control authorities, and calling for increased enforcement action against brokers who facilitate diversion.

The third part of our efforts is aimed against the traffickers themselves. This effort has involved close cooperation and information sharing among the drug control authorities in Europe and North America. These efforts have resulted in seizures of approximately 57 tons of methaqualone, destined for the United States illicit market in 1981. This represents more than a fourfold increase over 1980 seizures. Combining the 57 tons of seizures with the 40 to 50 tons that was not manufactured in Europe, you can see that we have gone a long way toward reducing the supply of methaqualone.

The results of the combined diplomatic and cooperative efforts have been impressive. We have already received reports that there is a scarcity of methaqualone powder in South America destined for clandestine tableting operations, and there are no pending ship-

ments of methaqualone from the primary shipping port of Hamburg, Germany.

More importantly, reports of injuries due to abuse of methaqualone in the United States show a decline of one-third in the third quarter of 1981, compared with the same period in 1980.

While we appear to have turned the corner on the problem of international diversion of methaqualone, we still have major difficulties. Recently, we have seen substantial evidence of widespread diversion and abuse of other legitimately controlled substances, such as amphetamine, methamphetamine, valium and others, which have been diverted from international commerce. They are in some cases substituted for now hard-to-obtain methaqualone and counterfeit Quaalude tablets. We are in the process of initiating parallel actions regarding these additional drugs.

Our experience with methaqualone has shown us not only how quickly a problem can develop, but also how our ideas on drug trafficking must keep up with the changing times. The trend toward abuse of a wide range of drugs is continuing, and our concepts of traditional drug trafficking patterns must accommodate these trends.

Senator, that concludes my prepared remarks, and I am ready to answer any questions you may have.

[The prepared statement of Mr. Mullen follows:]

95-556 O—82——3

STATEMENT OF FRANCIS M. MULLEN, JR., ACTING ADMINISTRATOR, DRUG ENFORCEMENT ADMINISTRATION, U.S. DEPARTMENT OF JUSTICE

Chairman Hawkins and Members of the Committee:

I appreciate this opportunity to appear before you to discuss a drug trafficking problem that affects many Americans and has now spread to other countries. The drug is methaqualone, known by its trade and street names as "Quaaludes," "Sopors," or just "Ludes."

Methaqualone represents a serious health problem and also a serious law enforcement challenge. In 1981, due primarily to a DEA initiative, law enforcement authorities seized over 57 metric tons of methaqualone in illicit channels of distribution, mostly destined for the illicit U.S. drug market. This was a substantial increase over the 12.6 tons of methaqualone seized in 1980. Estimates for 1980 and 1981 have indicated that at least 120 tons of legitimate methaqualone powder were diverted each year into the illicit market.

When one considers that the annual legitimate medical distribution of methaqualone from the United States in 1981 was only 4.2 metric tons, the extent of diversion, in light of these enormous seizures, is all too evident. If the 57 tons in 1981 were tableted and sold on the illegal market at their street value of $5.00 per tablet, the profits to the traffickers would have been over one-half billion dollars.

Methaqualone was first introduced to the United States in 1965 as a sleeping aid which was available by prescription, but was not under Federal control. Methaqualone is a central nervous system depressant, effective for sedation and for sleep. Onset of sedative action occurs within 10 to 30 minutes of ingestion, and lasts between 6 and 8 hours. Habitual use of the drug results in addiction, and very high doses can cause coma or death. The drug is particularly attractive to drug abusers because it can produce euphoric effects.

Several years after the drug was introduced to the United States market, Federal officials began to notice an increasing number of reports from law enforcement and health authorities on methaqualone abuse and misuse. In response to what appeared to be a growing problem, in 1973 the Drug Enforcement Administration placed methaqualone in Schedule II of the Controlled Substances Act. Schedule II control measures provide for: (1) a restrictive quota system limiting the manufacture of such substances to meet the estimated medical, scientific, research and industrial needs of the United States and for lawful export requirements, (2) extensive import/export provisions requiring among other things, written authorization of every shipment from the importing country drug control officials prior to exportation; (3) the requirement that all drug transactions in this schedule be pursuant to an official government order form (this form enables the DEA to monitor purchases and sales of these drugs from the manufacturer

to the distributor to the retail pharmacy or doctor); and (4) extensive reporting to DEA of all transactions by manufacturers and distributors.

Although these control measures placed methaqualone in the most stringent control status available in the United States for drugs which have a legitimate medical use, methaqualone continued to be abused. This was clearly substantiated by the steady increase in the Drug Abuse Warning Network (DAWN)* statistics for methaqualone injuries and deaths from 1978 through 1980. According to the DAWN national reports on methaqualone, deaths and injuries attributable to this drug have been increasing more rapidly than any other single drug substance. The DAWN report showed 2,389 deaths and injuries in 1978, increasing to 3,368 in 1979, and finally 6,091 in 1980, for a total increase of 154 percent. Miami, Florida, and New York City reflected the largest number of emergency room incidents. These two cities account for over 41 percent of the total number of methaqualone emergency room mentions. Additionally, a comparison of 1977 through 1980 data among cocaine, heroin, and methaqualone showed that methaqualone was by far the most rapidly increasing drug found in emergency room mentions. In three years time, it has become one of

*Project DAWN is a substance abuse data collection system co-sponsored by the Department of Justice through the Drug Enforcement Administration and the Department of Health and Human Services through the National Institute on Drug Abuse.

the most popular and widespread drugs of abuse across the nation and throughout society. In 1981, adolescents reported methaqualone as the most popular drug of choice, next to marihuana.

Trafficking Patterns

Methaqualone trafficking patterns and practices have developed to accomodate the various elements of the illicit drug market. Unlike other drugs which travel totally in illicit channels of distribution, methaqualone trafficking involves a licitly-produced substance which travels in legitimate commerce. Methaqualone trafficking involves diversion from two sources of supply. The primary source of supply is from foreign pharmaceutical suppliers. The second is from domestic sources usually under the guise of "stress clinics."

Briefly, methaqualone is manufactured in Europe for worldwide consumption. The bulk powder is transported through international commercial channels, whereupon it is clandestinely tableted elsewhere and then smuggled into the United States. There are many points along this manufacturing and distributing chain in which international authorities have encountered problems controlling the diversion of methaqualone from this legitimate enterprise. In the fall of 1980, DEA analyzed trafficking patterns that had become evident as a result of large seizures of methaqualone tablets by Federal, state,

and local enforcement agencies. Analysis of these tablets by DEA's Special Testing Laboratory, established three facts: (1) the tablets looked like legitimate Quaalude tablets produced and distributed in The United States, (2) in spite of their appearance the tablets were, in fact, counterfeits, and (3) in spite of the counterfeit nature of the tablets, they contained methaqualone which had been legitimately produced somewhere.

Thus, it became apparent that because of the United States' scheduling actions and controls on methaqualone, traffickers were forced to look outside the U.S. to obtain supplies of methaqualone. European pharmaceutical suppliers unwittingly had become sources of supply for the illicit distribution of methaqualone in the United States.

Three primary conditions nurtured this drug trafficking pattern. First, many large manufacturers of pharmaceuticals and chemicals are located in Europe, where regulatory controls are often less restrictive than those of the United States. Second, many European nations are not party to the International Convention on Psychotropic Substances, which controls drugs such as methaqualone. And third, international drug control treaties only provide a minimal framework for the control of drugs in international commerce.

Diversion from International Commerce

Before I explain how methaqualone is diverted from international commerce, it is important to explain the concept of free trade zones and their relationship to narcotics trafficking. A free trade zone is an enclosed area in a seaport, airport, or other inland point where goods of foreign origin are brought pending eventual transhipment, re-exportation or in some cases, importation into the country where the free trade zone is located. Free trade zones are intended to stimulate and promote commercial trade and, by design, simplify the movement of goods by offering exemptions from government controls such as record keeping and inspection regulations imposed by customs authorities and other responsible drug control authorities.

Drug traffickers take full advantage of the anonymity and confidentiality provided transactions in free trade zones as opportunities for drug diversion. For example, the Hamburg free trade zone, which is a major commercial port in Europe, has also served as the primary transit point for diverted pharmaceuticals destined for the illicit United States drug market. By tracing airway bills and other shipping documents, DEA has been able to determine that during 1981, over 38 tons of methaqualone were diverted through the Hamburg free trade zone, clearly indicating the major role that free trade zones play in the diversion problem.

Diversion and Trafficking Methods

The following illustration is typical of how methaqualone is diverted from international commerce and ultimately smuggled into the United States. By using false letterheads, addresses, and perhaps forged importation documents, traffickers represent themselves to brokers in European free trade zones as "legitimate" purchasers of the drugs involved. The brokers, in turn, place the order with a major manufacturer and arrange for necessary shipping, without verifying the legitimacy of their customers. In this fashion, millions of dollars in potential illicit profits are obtained for mere thousands of dollars in investments. The substances then move to their destination without detection, because most customs officials are looking for different types of drugs, i.e., heroin, cocaine, and marihuana, which are smuggled in an entirely different manner.

The trafficking scheme is more complicated when the broker, in collusion with the violator, intentionally mislabels the narcotics as "harmless chemicals," "fertilizer," or "soda ash". By tracing air bills and other documents obtained from methaqualone seizures, DEA has been able to document these diversion techniques and practices back to the country of origin.

The diverted substance is then shipped to clandestine laboratories for conversion into tablets, which are made to resemble those produced by legitimate manufacturers. The majority of clandestine tableting of methaqualone occurs in

Col@mbia; to a much lesser extent, some tableting also occurs in Mexico. The pills are designed to resemble Quaaludes, which are the only legitimately-produced pill form of methaqualone available in the United States. Shipments of the counterfeit tablets are then transported by traditional smuggling modes, such as light aircraft and vessels, to destinations in the United States and throughout Europe.

Enforcement Initiatives

In response to this problem, the Drug Enforcement Administration launched a three-pronged attack on the international diversion of methaqualone. The first assault involved diplomatic initiatives between the United States and foreign producing nations to curtail the manufacturing and exporting of methaqualone.

In late 1980 and in early 1981, DEA and the State Department undertook a series of diplomatic initiatives with several nations designed to increase cooperation and eliminate the sources of diversion. In response to our initiatives, the Fedoral Republic of Germany, a major source and transit country of psychotropic substances, imposed stringent import and export control measures. During this period, Hungary, another leading source country, voluntarily curtailed the production and exportation of methaqualone. In addition, Austria, a third producing country, recently curtailed methaqualone production. These actions removed at least 40 to 50 tons of methaqualone that would have been available

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for diversion to the United States illicit market and represented a significant step toward a long-range solution by eliminating availability at the source.

In conjunction with these efforts to eliminate the supply of methaqualone, DEA has, with support of the State Department, engaged in a diplomatic campaign to prevent this drug diversion problem. For example, we have used our leadership role in international drug control bodies to reduce the flow of illicit drugs to the United States. At the 29th Session of the United Nations Commission on Narcotic Drugs (CND) held in February 1981, DEA played a key role in the adoption of a resolution calling for certain voluntary measures to prevent the diversion of legitimately-manufactured drugs from international commerce.

More recently, at its seventh special session held in February 1982, the CND unanimously passed two significant drug control resolutions offered by the United States. One resolution expands the role of international drug control authorities to monitor and report the suspicious movement of controlled substances in international commerce. The other resolution calls for increased action against brokers who intentionally facilitate the diversion of controlled substances. International drug control authorities are also calling for increased monitoring programs by customs authorities to identify the suspicious movement of pharmaceuticals in international commerce.

To assist drug law enforcement authorities in the identification of suspicious shipments, DEA has prepared a Drug and Chemical Watch Manual. The manual provides basic technical and investigative guidance to assist customs personnel in the identification and interdiction of illicit shipments of diverted pharmaceuticals and chemicals in international commerce. Copies of these manuals have been distributed to U.S. Customs field offices for their use and a foreign version, in several languages, is now being distributed to foreign customs and drug law enforcement authorities.

Another positive result in the effort to prevent the diversion of methaqualone within international commerce occurred in June 1981, when the Government of Colombia ratified the Psychotropic Substances Convention of 1971, the international drug control agreement under which methaqualone is controlled. Taking advantage of Article 13 of this agreement, the Government of Colombia has notified international drug control authorities that the importation of methaqualone is prohibited and the exporting countries are not to approve shipments to Colombia.

These examples reflect the success we have had in reducing the availability of methaqualone and demonstrate the effectiveness of diplomatic and regulatory initiatives. Such efforts, however, can not completely eliminate the diversion of methaqualone from international commerce. To complement these initiatives, a willingness to cooperate and share information by international regulatory agencies and industries is also essential.

For example, as a result of close cooperation and information sharing among drug control authorities in Europe and in North America, Canadian authorities seized over 5,600 kilograms of methaqualone that was destined for the United States illicit drug market. Investigation revealed a broker, with offices in Hamburg and Rotterdam, who ordered 10,000 kilograms of methaqualone from a European producer and had it sent to a Dutch firm, where it was repackaged from metal drums into fiber bags and intentionally mislabeled as "Soda Ash." To further avoid detection by law enforcement authorities, the bags were concealed within shipping containers with other bags of soda ash and shipped from Rotterdam to consignees in the United States, Canada and the Caribbean.

In another example of close cooperation among the drug control authorities of several nations, Panamanian authorities seized a total of 8,750 kilograms of methaqualone powder destined for clandestine tableting laboratories in Colombia. The methaqualone was shipped from the freeport of Hamburg to the Frankfurt airport via truck. The shipments then went via commercial airlines to Madrid and on to Panama. The methaqualone was of Austrian origin and was brokered by a Federal Republic of Germany firm. One shipment was marked "Producto Quimico Sodium-methyl-Benzoato 5, Harmless Chemicals - not restricted" to a firm in Colon Zona Libre, Panama.

These cooperative investigations have had a significant impact on reducing the flow of psychotropic substances to illicit channels of distribution. More importantly, they represent an integral part of our overall drug strategy to curtail this diversion problem. This strategy employs a series of activities in which intelligence collection, diplomacy, operations, and international cooperation are merged together. First, intelligence derived from arrests and seizures provides the basis for diplomatic discussions. These, in turn, increase the flow of operational intelligence and thus make further arrests and seizures possible. The result is the creation of additional knowledge upon which to base further diplomatic initiatives. The effort has involved the active cooperation of a number of governments, especially the Federal Republic of Germany, Hungary, Austria, Mexico, Colombia, Canada, Panama, the Netherlands, the United Kingdom, and others.

In terms of reducing the availability of methaqualone, the effects of this strategy are impressive. In the first months of 1982, United States law enforcement authorities seized only approximatley 1,100 kilograms of methaqualone in illicit channels of distribution. This is a dramatic drop from this same period for 1981, when authorities had seized over 11,500 kilograms of methaqualone. In addition, our intelligence indicates there is a scarcity of methaqualone powder in South America for clandestine

tableting operations, and there are no pending shipments of methaqualone from the primary shipping port of Hamburg. More importantly, reports of injuries due to abuse of methaqualone in the United States show a decline of one-third in the third quarter of 1981 when compared with the same quarter in 1980.

Diversion from Domestic Sources

The diversion of methaqualone from domestic sources also feeds the illicit United States drug market. Legitimately produced methaqualone tablets are prescribed in "stress clinics" that are being established throughout the United States. These clinics are typically set up as independent corporations by non-medical financiers who are knowledgeable of the existing case law which has determined the standards of legitimate medical practice. The physicians and other staff personnel are recruited through newspaper advertisements and through professional placement agencies and the physicians have no control over the clinic's operation or its standards of medicine.

Each clinic has a set program of physical and/or psychological examinations for all new patients which has been specifically developed to present the appearance of legitimate medical problems needing treatment. After receiving the examinations, and paying a fee of $100-$125, the patient is usually given a prescription for Quaalude. In order to reinforce the appearance

of legitimate treatment, each patient is allowed only one prescription every 30 days. The stress clinic phenomenon is widespread, and clinics have been identified in Boston, New York, New Jersey, Chicago, Los Angeles and Miami.

Because all patients are given a medical examination, it is difficult to employ the traditional undercover buy approach in these cases. Documentary cases on these clinics have been developed by examining bank and corporate records, analyzing prescription information and interviewing former clinic employees. Significant actions against the individuals who are organizers of these stress clinics are anticipated in the near future.

In addition to these enforcement activities, the Drug Enforcement Administration is taking other action to reduce the availability of methaqualone from domestic sources for illicit purposes. DEA establishes production quotas based in part on the previous year's legitimate use. They were reduced from 16,000 kilograms in 1978 to 9,600 kilograms in 1979 to a little over 4,000 kilograms in 1980. The need for further significant reductions is now being examined in light of the accumulated inventories of methaqualone from previous years.

In addition to Federal actions, two states have determined that methaqualone has no legitimate medical use. The State

of Florida has placed it in Schedule I under state law effective July 1, 1982, and the State of Georgia has a similar bill under serious consideration.

Diversion of Other Controlled Substances

While we appear to have turned the corner on the problem of international diversion of methaqualone, we have seen substantial evidence of widespread diversion and abuse of other legitimately-produced controlled substances diverted from international commerce. In some cases, those substances are substituted for methaqualone in counterfeit Quaalude tablets. In one investigation, drug enforcement authorities in North America seized a total of 550 kilograms of diazepam, which is marketed in the U.S. legitimately as Valium. The drug authorities seized diazepam powder, tableting equipment and diazepam tablets make to look like legitimately-produced methaqualone tablets. Follow-up investigation produced evidence that additional shipments of diazepam tablets, totaling 700 kilograms, had been diverted from European sources to the clandestine tableting laboratory.

In another case, several Mexican nationals were recently arrested for diverting approximatley 1,000 kilograms of methamphetamine, a Schedule II controlled substance, from international commerce. Using the names of three fictitious firms in Mexico, the drug traffickers purchased the methamphetamine powder from legitimate suppliers in Europe and had

it shipped to clandestine laboratories in Mexico. All but 350 kilograms of the powder, which was seized by the Mexican Federal Police, was utilized in the clandestine tableting of "mini-bennies" and smuggled into the United States. These same violators attempted to divert over 1,000 kilograms of secobarbital, another Schedule II substance, from another European supplier, using similar diversion techniques and practices.

Similar cases of diversion from legitimate sources have been documented involving other drugs of abuse such as amphetamine, morphine, pentazocine and others. It is also significant to note that this illicit market is rapidly expanding. Shipments of counterfeit methaqualone and diazepam tablets have been seized which were destined for countries in the Middle East and Africa. Moreover, the demand for counterfeit pharmaceuticals in the illicit drug market favor easily recognized or "brand name" pharmaceuticals, such as methaqualone tablets marked "Mandrax" or "Lemmon 714" and hydromorphone tablets marked "K-4."

In some cases, samples of the tablets seized in illicit traffic, upon laboratory analysis, have been found to contain dangerously high levels of controlled substances and/or toxic substances. In other cases, laboratory analysis of the tablets disclosed they contained controlled and/or noncontrolled substances in combinations or quantities

different from legitimate preparations, thus creating a significant public health hazard.

Based on our recent success with methaqualone, it is clear that we must take parallel actions to combat the diversion of these additional drugs of abuse. We have begun to develop diplomatic and regulatory initiatives from the information gleaned from recent investigations and have increased enforcement programs accordingly.

In conclusion, Senator Hawkins, I believe that the international community is sensitive to the methaqualone problem and is committed toward minimizing the abuse of this substance. The interest and support you have shown us by holding this hearing is gratifying. Thank you. I would be pleased to answer any questions you or other Subcommittee members may have.

Senator HAWKINS. Thank you.

The DEA sets quotas for domestic production levels of methaqualone; is that true?

Mr. MULLEN. I will have Mr. Haislip answer that.

Senator HAWKINS. Mr. Haislip?

Mr. HAISLIP. Yes; we do set quotas for production and distribution of methaqualone.

Senator HAWKINS. Could you tell me how that system works?

Mr. HAISLIP. Yes. Basically, we gather evidence from various sources, including the Federal health authorities, as to what appears to be the legitimate need for each major drugs of abuse. Based on this information, we establish a quota to meet that legitimate need. We are especially careful in considering drugs which have a high degree of abuse, to limit the quota to insure that the amount produced or made available is sufficient to fulfill only the legitimate need as recognized by the Federal medical authorities.

Senator HAWKINS. What does the quota level mean in terms of the availability of methaqualone?

Mr. HAISLIP. Well, this is a little complex, if I may take a moment.

Senator HAWKINS. Surely.

Mr. HAISLIP. We had in this country a single manufacturer of this drug. Because of problems which had developed due to lack of security and leakage of the drug from that manufacturer, DEA took action against the manufacturer. An agreement was reached so that today, there is no domestic manufacture of this drug whatsoever. However, there were stocks, and the stocks were acquired by the single company that presently has the right to distribute methaqualone legitimately. That company does have plenty of

stock on hand. We are still in the position legally of determining how much of it they may dispose of in a given year, and we are indeed going through that very exercise at the moment. We expect to sharply reduce the amount that has been available as a result of the very problems that you have so aptly summarized.

Senator HAWKINS. What percentage of the smuggled Quaaludes end up in south Florida?

Mr. MULLEN. It is hard to give the exact percentage, but we are well aware that the most serious problems with regard to methaqualone, the cities most affected, are Miami and New York.

Mr. HAISLIP. Forty-one percent of the national total of all of the incidents are between those two centers. It is fair to say that Florida is the single State that is most grievously affected.

Mr. MULLEN. What we are talking about are the reported injuries and deaths due to methaqualone. Forty-one percent occur in New York and Florida.

Senator HAWKINS. Is there any kind of international control exercised over shipments of dangerous narcotics, such as Quaaludes?

Mr. HAISLIP. Yes, there is. This drug is subject to a treaty which most, but not all, manufacturing nations are members. There are controls and they are useful controls. They are not entirely adequate, but the difficulty has been that they have been only informally attended to. It was necessary to raise the level of attention to the controls which are required, and this is what we have attempted to do.

Senator HAWKINS. What role does the Psychotropic Convention contribute to this control?

Mr. HAISLIP. This is the treaty to which I was alluding.

Senator HAWKINS. That is the treaty's name?

Mr. HAISLIP. Yes. It does require some very useful controls.

Senator HAWKINS. What are its limitations?

Mr. HAISLIP. Well, the limitation, Senator, is a little technical, but if you will bear with me for a moment.

I would like to contrast it with the requirements of our own law.

Senator HAWKINS. Surely.

Mr. HAISLIP. We will not permit shipments of drugs such as methaqualone to any country, unless it has been established not only that the country has issued an appropriate import permit, but also that there is a legitimate need for the drug in that country and that the drugs will not be further exported. Now, the treaty does not go as far as our own law. It simply requires the issuance of a permit and, of course, in some cases, these permits have been falsified.

Senator HAWKINS. You mention that in the last half-year, great strides have been made in eliminating Quaalude traffic, and I commend the DEA for their efforts in this regard. But what enforcement strategy will you be employing in the future?

Mr. MULLEN. We will be taking a close look at the so-called "stress clinics" and following their activities—and I can only describe the stress clinics as a fraud being perpetrated upon the American public—and we will closely watch the diversion of the methaqualone. We will look for trends. We hope to reduce the illicit supply available to somewhere well below 3 tons, which will make less of a supply available for diversion. We intend to stress

the overseas cooperative efforts with not only the countries manufacturing, but also the countries used as transit points, such as England, Colombia, and Panama. So, we will be looking for a reduction in the overseas production and shipment and also stressing the enforcement in this country.

Senator HAWKINS. I understand that the drugs effectiveness is lost after 2 weeks of use. Why would so-called legitimate use of the substance be so widespread?

Mr. MULLEN. Well, that is the question I have to leave to the medical profession and to the Food and Drug Administration. I stress that my testimony is from the enforcement standpoint.

Senator HAWKINS. Has the Federal task force to arrest the heavy flow of narcotics into Florida had any substantial impact?

Mr. MULLEN. It has had a very substantial impact, Senator Hawkins. In some cases, the ships and planes have just stopped coming. We have found, in fact, in some areas in Florida an 80- to 90-percent reduction in the trafficking. Now, it may well be that this activity will move to the west coast or further up the east coast, as far north as Maine. We have seen some indications of that. But it has given law enforcement at the Federal, State and local levels a breather, a time to prepare our cases, get on with our current investigations; and as you know, the traffickers are dealing with a perishable product. I think it has had a tremendous impact. We cannot keep going forever with this high level of enforcement, but we do intend to maintain a high level of enforcement in Florida. As you know, DEA has permanently transferred 20 additional agents, the FBI 43; and we will have some form of a task force for some time well into the future. That is beyond the 3 months or 6 months that we are talking about. We will stay there just as long as we have to.

Senator HAWKINS. As the last question, could you explain the chart on the wall over there, which portrays the path of international traffic for me, please? I may have to leave before the next panel to go and vote, but I will be right back, for the second panel.

Please proceed.

Mr. HAISLIP. Yes, if I may, we have three charts here. The first one simply shows the level of our seizures. You can see that as a result of the program which we initiated, our seizures have skyrocketed to quite an impressive level. That was working with the other nations involved.

This chart shows the medical reports that we received concerning deaths and injuries, and again, you see a very sharp trend upward, but it is beginning to come down. Now, at this point, the decline is not so impressive as we would like. We believe that the reports we are going to see this year are going to show a sharp downturn.

Finally, this chart here basically shows the traffic in international diversion of methaqualone, which centers out of Europe through the free ports, principally Hamburg, into Colombia primarily, Mexico and Canada secondarily, all of which comes to the United States. And here, the sources of supply are indicated—Austria, Hungary, West Germany, China, and other countries which are involved as victims of this traffic. So this is basically what we have.

Senator HAWKINS. Thank you both very much for participating.

We will excuse this panel.

Mr. MULLEN. Senator, thank you so much for your support.

Senator HAWKINS. Thank you.

The second panel will be Capt. Fred Dunphy, from Miami, Fla.; Mr. David Poythress, secretary of state of Georgia; Mr. Michael Fowler, joint secretary of the Georgia State Examining Board from Atlanta, and Dr. Marshall Swartzburg of Rutgers Medical School.

At this point, I will go vote and be right back.

[Short recess.]

Senator HAWKINS. We are back on the record.

We will begin the second panel with Captain Dunphy, who I have previously introduced.

STATEMENT OF CAPT. FRED DUNPHY, METRO DADE POLICE DEPARTMENT, DIVISION OF VICE, NARCOTICS AND INTELLIGENCE, MIAMI, FLA.; MICHAEL FOWLER, JOINT SECRETARY, STATE EXAMINING BOARD, ATLANTA, GA.; DAVID B. POYTHRESS, SECRETARY OF STATE, ATLANTA, GA.; AND DR. MARSHALL SWARTZBURG, ASSOCIATE PROFESSOR OF PSYCHIATRY, RUTGERS MEDICAL SCHOOL, PISCATAWAY, N.J., A PANEL

Captain DUNPHY. Thank you, Senator Hawkins.

I am currently a captain with the narcotics section of the Metro Police Department of Dade County, Fla. I have been in law enforcement for approximately 11 years, where my career has been involved with the narcotics enforcement aspect for approximately half that time. I am currently assigned as the commanding officer of my department's narcotics section, which is responsible for enforcing the law as it applies to illicit drugs.

We have 48 officers and supervisors currently assigned. Our county, whose seat is Miami, is approximately the size of Delaware and has a population of about 1.8 million. Dade County, as you know, has been well established as the wholesale capital of the drug world.

I thank you for inviting me to testify, and I look forward to your questions.

Senator HAWKINS. Could you describe for us the typical Quaalude investigation from the point of discovery to the actual apprehension of the subject?

Captain DUNPHY. Yes; Senator. May I use the chart, possibly?

Senator HAWKINS. Surely.

Captain DUNPHY. The case which I am going to detail to you—and there are several different cases up here on the board—but probably the one that is the most interesting is a recent case we had involving the shipment of over a ton of Quaalude powder. The pictures here show an abandoned residence where the powder was stored, and the second picture is of the bags. We had some seepage there, which was extremely hard for our detectives to handle when we processed it. Inside the abandoned residence, we were able to apprehend four Colombian nationals who were bringing this methaqualone powder into the residence for storage up to about 3 days. Since we made that initial seizure, we have been able to backtrack it to the original owner of the Quaaludes, and the person who paid to have it shipped and processed, and it has been discovered

through DEA lab analysis that this particular load was 99 percent pure, which is the highest that the Drug Enforcement Administration had ever received.

Currently, the Drug Enforcement Administration is also interested, and they have become involved with us on this case, and it may tie into several seizures in other areas of the country, large-scale seizures. The impact of this particular seizure is that once the process was to take place and the pills were pressed, you are probably talking around 7 million tablets at this strength. So in terms of what impact it had, I feel it was a significant case.

Senator HAWKINS. Where is the drug sold?

Captain DUNPHY. The drug is sold at a number of locations across any community in the country, really. You can find it anywhere from the school to a cocktail lounge.

Senator HAWKINS. Who buys it?

Captain DUNPHY. Generally, I think it cuts pretty much across socioeconomic lines.

Senator HAWKINS. Is there any particular age bracket where it is most abused?

Captain DUNPHY. Probably it is a little more popular among the youth. It is something that has come into vogue, so to speak, in terms of narcotics, only fairly recently, and I think that has a tendency to lend itself to usage more so than marihuana, which has been around a long time, and cocaine, and heroin.

Senator HAWKINS. What do they pay for it? What is the average price for a single Quaalude?

Captain DUNPHY. On the streets of Dade County right now, you can pay anywhere from $3 up to $7 a tablet. If you are talking about large-scale wholesale distribution, which we run into most frequently down there, you may be able to purchase it for 75 cents a tablet, 50 cents a tablet, in its processed form—maybe even cheaper at times.

Senator HAWKINS. How does the average Quaalude deal compare with cocaine and marihuana deals?

Captain DUNPHY. Well, I think the deals basically work much the same. I think the drug culture has evolved to a point where we almost have an operating procedure among these people. It is pretty much the same if you are talking about cocaine, marihuana, or Quaaludes.

Basically, I think most of the dealers we have found who deal Quaaludes will also deal cocaine and marihuana; they kind of have their hands into everything. You will not find that with cocaine dealers and marihuana dealers, as a general rule. Generally, the Quaalude dealers will deal all three; marihuana dealers generally will stick with marihuana, and cocaine dealers will generally stick with cocaine. Very rarely do we run into people who, on the wholesale market now, deal strictly in Quaalude.

Senator HAWKINS. How has the Quaalude use increased in the last 5 years as compared with other popular drugs?

Captain DUNPHY. In Dade County, we found a significant increase. It has taken off much more so than marihuana and cocaine. Our seizures in 1979 were about 250,000 tablets; in 1980, we increased it to about 350,000. Last year, it was over 3 million——

Senator HAWKINS. 3 million?

Captain DUNPHY. 3 million tablets. And this year, we have already topped last year's seizure record. So we are looking at even more.

Senator HAWKINS. So in the first few months alone of 1982 you are over 3 million?

Captain DUNPHY. Yes.

Senator HAWKINS. Is the increase in seizures that we have heard about this morning a reflection of more effective law enforcement efforts, or is it merely a reflection of a far greater demand for the drug?

Captain DUNPHY. Well, I think probably what you have is a little bit of both. Our enforcement efforts, speaking from a local standpoint, have increased significantly in the last year and a half. We have been able to acquire and use the services of the Drug Enforcement Administration to a much greater extent. Our department went through something that was kind of unique in law enforcement. We went through a major riot, as you will recall, and we had some problems in terms of manpower, and we just got back on our feet about 1½ years ago, and we have been increasing ever since, and I think that has made an impact. One of the things I feel may be a factor in the increase of Quaaludes on the market is that we have been picking up some intelligence data, and it is very sketchy at this time, but it may tie in, that some of the cocaine labs have been disrupted in Colombia. And we have found evidence that possibly, labs are going to be set up in this country to process cocaine. And I think it is kind of a stopgap measure for some of the cocaine dealers to switch over to methaqualone for a period of time until they can get their operation back on the right track.

Senator HAWKINS. Could you explain for us the operation of the clandestine laboratories that process the powder into pill form?

Captain DUNPHY. Yes, Senator. What we have in this country basically are not laboratories. What we have are pill manufacturing outlets. And again, if I could use the chart, the top two pictures here are pictures of a Quaalude pill press. This is a picture of the press and the crusher side by side, and what they will do is they will take any unsaleable tablets—in other words, they have imperfections to where they could not sell them on the street—they will recrush them in powder form and then put them with the other powder into the machine to press the pills. The dies are up there at the top—I do not know whether you can get a shot of that or not. Basically, this operation here is a one-man operation, and it does not require more than that. It is kind of surprising—if the guy is good. He might have another person working with him, but generally, it can be run with one person. It is capable of producing 750 tablets a minute, and the entire operation, excluding the dies, would run around $30,000 for the equipment. Now, the dies, depending on where they get them—they are usually on the black market—could run anywhere from $1,000 up to $4,000 apiece for the stamps.

So you are talking, in terms of monetary outlay to get the operation rolling, it is pretty significant.

Senator HAWKINS. What would that bring? The 750 tablets a minute, what would they sell for?

Captain DUNPHY. They could run through this ton of Quaalude powder in probably a week without working very hard at it.

Senator HAWKINS. What steps are followed in the selling process?

Captain DUNPHY. After the pills are processed in this type of machine, generally, they would go to a wholesaler, and they would be sold on a large scale. Normally, when we have found operations like this, they are in an abandoned house, and not much activity of people in and out to draw attention to them. They are not really selling Quaaludes out of this particular location. They are manufacturing them from the powder and then selling them on the wholesale market.

Senator HAWKINS. How much revenue would that ton bring?

Captain DUNPHY. An operation like this, yearly?

Senator HAWKINS. Yes.

Captain DUNPHY. Several million dollars yearly revenue generated from one press.

Senator HAWKINS. Is that after taxes? [Laughter.]

Captain DUNPHY. It depends if IRS gets ahold of them or not. But yes, it is a significant profit margin.

Senator HAWKINS. What is the supply ratio of illegal Quaalude, versus pharmaceutical Quaaludes in south Florida?

Captain DUNPHY. Generally, I think what we are finding is about 90 percent illicit Quaaludes, or bootleg, as we call them, and about 10 percent pharmaceutical.

Senator HAWKINS. Is there any difference between the user of the illicit Quaalude versus the prescribed Quaalude?

Captain DUNPHY. I think probably what we have found is that the person who is going to use pharmaceuticals is generally a little bit older and maybe a little bit wiser, and he has got the money and the age to go into a stress clinic and appear to be legitimate when he goes in there.

I would think that a stress clinic would tend to turn away a 14- or 15-year-old, or a teenager of relatively young years, or a youth, where they would not turn away an older person. The air of legitimacy would be increased as the person got older. So I think what you would find is the bootlegged Quaaludes being used up by the younger people.

Senator HAWKINS. You say 90 percent of Quaaludes are illicit. Does it pose a law enforcement problem when you have an illicit drug like that that is also prescribed?

Captain DUNPHY. I believe it does. What we tend to do, I think—and this is my own personal opinion—is legimatize the aspects of the drug, and we almost send a message to people that somewhere along the line, it is OK to abuse this drug or at least use it heavily.

Senator HAWKINS. In south Florida, do you have any statistics that tell us how young the kids are that are using this?

Captain DUNPHY. No; I do not have any figures on that. We have discovered them in all levels of the public school system.

Senator HAWKINS. Junior high?

Captain DUNPHY. Junior high and high school.

Senator HAWKINS. Florida recently passed legislation which banned the prescription use of methaqualone. Are you happy about that?

Captain DUNPHY. I think it is a step in the right direction. Any time we can send a message to people that drugs are not OK, I think it is a step in the right direction.

Senator HAWKINS. Thank you very much, Captain.

Captain DUNPHY. Thank you, Senator.

Senator HAWKINS. The next witness today will be Mr. David Poythress, who is the secretary of state for Georgia. We are happy to have you with us today. Do you have a statement?

Mr. POYTHRESS. Thank you, Senator.

Madam Chairman, I appreciate this opportunity to appear before your committee and discuss the seriousness of Georgia's methaqualone or Quaalude abuse problem and our recent legislative attempts to crack down on the increasing availability of this drug through seemingly legitimate sources.

One of my primary responsibilities as Georgia's secretary of state is the administration of the 39 State regulatory boards, which includes providing investigative support and legal assistance coordination to both the composite State board of medical examiners and the State pharmacy board.

As secretary of state, I have taken a particular interest in strengthening our regulatory activities within the health professions, with particular efforts to combat the growing drug diversion problem in Georgia.

Having spent the early part of my career in State government as an assistant attorney general representing the State regulatory boards, I am acutely aware of the difficulties and the frustrations of proving cases against physicians and other health practitioners in areas involving ethical practice and acceptable medical practices through either the courts or administrative regulatory boards. When a drug abuse and diversion problem becomes as extensive and widespread as the methaqualone problem had become in Georgia, it is time to seek legislative approaches as we did in Georgia, in addition to the disciplinary procedures already available through the professional regulatory boards.

In the latter part of 1981, our investigative and medical board staff became aware of a growing methaqualone abuse problem and significant increases in prescriptions being written for methaqualone in Georgia. Based on intelligence reports received from our investigative personnel, complaints received from physicians seeing more Quaalude abuse and overdose problems, and a continuing review of DEA statistical reports, the evidence of a growing Georgia epidemic mounted. By the end of 1981 Georgia ranked seventh nationally in the total base weight of Quaaludes prescribed and eighth in prescriptions on a per capita basis. Senator, that represented more than 214,000 grams of Quaalude or methaqualone that were sold in Georgia.

Furthermore, it became clear that the prescription problem was localized in pockets within the State. We found that 70 percent of the Quaalude prescribed in Georgia was prescribed in the Metropolitan Atlanta area, and almost 80 percent of that amount was prescribed in one ZIP code area where three of the so-called stress clinics are located.

Quaalude prescriptions in this one ZIP code area exceeded the cumulative annual distribution in 15 States. In fact, one pharmacy

in this area was dispensing approximately 25 percent of the State's total, or more than the total in each of 20 States and 2 U.S. territories.

Based on this and other information, the Composite State Board of Medical Examiners of Georgia began an undercover investigation of the practice of the stress clinics, including the taping of a telephone conversation between the manager of a stress clinic and a physician who was seeking employment. This portion of the investigation was conducted in conjunction with the Georgia Bureau of Investigations in meeting all legal requirements with regard to the taping. Our investigation was most revealing. We found that large quantities of methaqualone were being prescribed in small dosages to routine patients in the stress clinics. We confirmed that some 90 percent of the patients entering these clinics were receiving a prescription for Quaaludes. Due to the nature of this abuse and the difficulty in prosecuting individual physicians, my office joined with the composite State board of medical examiners after consultation with the Georgia Board of Pharmacy to seek legislation to move this drug from schedule II to schedule I of the Georgia Controlled Substance Act. This will effectively remove the drug from the marketplace in Georgia.

A great deal of support materialized for this legislation after its introduction from both of these medical groups, including the Medical Association of Georgia and the Georgia law enforcement community.

Our regulatory boards will continue to deal aggressively with the problem of prescription abuse through the normal disciplinary procedures. However, I feel that due to the unique nature of the methaqualone abuse problem and the difficulties of making individual cases against physicians, the legislative approach of placing methaqualone in schedule I was the only effective approach to Georgia's problem. I would encourage other States, as well as appropriate Federal committees and agencies, to consider carefully this serious problem and look closely at the possibility of following the lead of the State of Georgia and the State of Florida in implementing similar national legislation to deal with this growing national epidemic.

Madam Chairman, I understand you may have some questions.

[The prepared statement of Mr. Poythress follows:]

David B. Poythress
SECRETARY OF STATE

Secretary of State
State Capitol
Atlanta
30334

TESTIMONY OF GEORGIA SECRETARY OF STATE DAVID B. POYTHRESS
U. S. SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
HEARINGS BEFORE THE SUBCOMMITTEE ON INVESTIGATIONS AND OVERSIGHT
WASHINGTON, D. C.
MAY 13, 1982

Madam Chairman and Members of the Subcommittee, I am most appreciative of your invitation to appear at this hearing to discuss the seriousness of Georgia's methaqualone (Quaalude) abuse problem and our recent legislative initiative to crackdown on the increasing availability of this drug through seemingly "legitimate" sources. One of my primary responsibilities as Georgia's Secretary of State is the administration of the thirty-nine state regulatory boards which includes providing investigative support and coordinating legal assistance to both the Composite Board of Medical Examiners and the State Pharmacy Board. As Secretary of State, I've taken a particular interest in strengthening our regulatory activity within the health professions with particular focus on our attempt to combat the growing drug diversion problem. Having spent the early part of my career in state government as an assistant attorney general representing the state regulatory boards, and later serving for three and a half years as Commissioner of Georgia's Medical Assistance Program, I'm acutely aware of the difficulties and frustrations of proving cases against physicians and other health practitioners in areas involving ethical

practice and acceptable medical practices through either the courts or administrative regulatory boards. When a drug abuse and diversion problem becomes as extensive and widespread as the methaqualone problem had become in Georgia, it is time to seek legislation approaches as we did in Georgia, in addition to the disciplinary procedures already available through the professional regulatory boards.

In the latter part of 1981, our Investigative and Medical Board staff became aware of a growing methaqualone abuse problem and significant increases in prescriptions being written for methaqualone. Based on intelligence reports received from our investigative personnel, complaints received from physicians seeing more Quaalude abuse and overdose problems, and a continuing review of Drug Enforcement Agency (DEA), ARCOS Reports and Drug Abuse Warning Network (DAWN) Reports the evidence of a growing Georgia epidemic mounted. By the end of 1981 Georgia ranked seventh (7th) nationally in the total base weight of Quaaludes prescribed and eighth (8th) in prescriptions on a per capita basis. Furthermore, it became clear that the prescription problem was localized in pockets within the state. We found that seventy percent (70%) of the Quaalude prescribed in Georgia was prescribed in the metro Atlanta area and almost eighty percent (80%) of this amount was prescribed in one zip code area where three so called "stress clinics" are located. Quaalude prescriptions in this one zip code area exceeded the cumulative annual distribution in 15 states. In fact, one pharmacy within this area was dispensing approximately twenty-five percent (25%) of the state's total or more than the total in each of twenty (20) states and two (2) territories.

Based on this and other information, the Medical Board began an "undercover" investigation of the practice of the stress clinics including the taping of a telephone conversation between the manager of a "stress clinic" and a physician who was seeking employment. This portion of the investigation was conducted in conjunction with the Georgia Bureau of Investigations (GBI) in meeting all legal requirements with regard to the taping. Our investigation was most revealing. We found that large quantities of methaqualone were being prescribed in small dosages to routine patients in the "stress clinics". The Board also found that it was exceptionally difficult to make cases against physicians involved, due to the physicians carefully staying within the following guidelines:

(A) They were prescribing the drug for sleeplessness, which is a legitimate indication for the drug;

(B) They were not prescribing large single doses; and

(C) They were completing an evaluation of each patient, including psychological and physical evaluations, before prescribing the drug.

We confirmed that some ninety percent (90%) of the patients entering these clinics were receiving a prescription for Quaalude.

Due to the nature of this abuse and the difficulty in prosecuting individual physicians, my office joined with the Medical Board after consultation with the Pharmacy Board, to seek legislation to move this drug from Schedule II to Schedule I of the Georgia Controlled Substance Act. This will effectively remove the drug from the marketplace in Georgia. A great deal of support materialized for this legislation after its introduction from both medical professional groups, including the Medical Association of Georgia and the Georgia law enforcement community.

Our regulatory boards will continue to deal aggressively with the problem of prescription abuse thrcugh the disciplinary procedures. However, I feel that due to the unique nature of the methaqualone abuse problem and the difficulties of making individual cases against physicians, the legislative approach of placing methaqualone in Schedule I was the only effective approach to Georgia's problem. I would encourage other states and appropriate Federal Committees and Agencies to look closely at this serious problem and follow the lead of Georgia and Florida in implementing similar legislation to deal with this growing national epidemic.

Madam Chairman, I understand that you may have some questions at this time.

Senator HAWKINS. Yes, thank you so much, Mr. Poythress.

How did the medical board become aware of the problem of quaalude abuse in Georgia?

Mr. POYTHRESS. Primarily through intelligence reports that our agents picked up on the streets. In addition to that, we received increasing numbers of complaints and reports from practicing physicians, who were observing overdoses and drug abuse problems in their practices.

Senator HAWKINS. How was the stress clinic that was investigated by the medical board, discovered?

Mr. POYTHRESS. The particular clinic which we investigated most intensively and which is the subject of the conversation, a transcript of which is before you, was turned up by a report by a particular physician who had a patient who overdosed severely and nearly died from methaqualone. That patient had earlier visited a stress clinic in Atlanta, had received an extremely large prescription for methaqualone, had left the clinic and overdosed on it. That was reported to us, and that focused our investigation on that particular clinic.

Senator HAWKINS. Could you tell us how the clinic operated, including the medical examination and the psychological profile?

Mr. POYTHRESS. It is an interesting and a very carefully constructed exercise. It is a game, Senator, in which everyone knows the rules, and as long as everyone plays by the rules, drugs can be dispensed in a technically legal transaction, but for purposes which everyone knows to be illegal.

Routinely, a patient will present himself at the clinic complaining of sleeplessness—that is the consistent characteristic symptom for which methaqualone would be an appropriate medical prescription. The physician will conduct a complete physical examination. He will conduct what appears to be a psychological evaluation, at the conclusion of which he will prescribe methaqualone, usually in relatively small dosages. Thus, all of the bases have been touched: the patient has complained of the appropriate symptoms, the physician has gone through all the right motions, and he has made a prescription for what otherwise would appear to be a medically appropriate amount.

Senator HAWKINS. How was the tape recording made that you alluded to in your introductory statement?

Mr. POYTHRESS. A physician presented himself to the composite State board of medical examiners and my investigative staff, reporting his experience with this particular clinic. He had in fact worked at the clinic for several days, and his employment was terminated—he had terminated his employment because of problems and concerns that he had. In addition, he had had some problems getting a DEA number. He presented himself to our office, explained what was happening, and indicated a willingness to help. As a result of that, in cooperation with the Georgia Bureau of Investigation, he telephoned the clinic and engaged the manager in a conversation about the possibility of rehiring him at the clinic, and that is the tape that we have here today.

Senator HAWKINS. Before you play the tape for the benefit of the audience and the press, would you please explain whose voices we are hearing and their roles in the operation?

Mr. POYTHRESS. Yes, Senator. I should mention at the outset that the tape has been sanitized. There are no proper names used at all. For that reason, it may appear somewhat stuttering at parts of it. You will hear two voices. The first is the voice of the physician. He is a foreign-trained physician and has what sounds to be a Latin accent, and it is a little difficult to follow him at times. The other voice is that of a woman who is the manager of the clinic. She is not a physician. At the early part of the conversation, you will hear reference made to whether or not the physician has yet secured his DEA number, that of course being a condition to his reemployment by the clinic. If you listen carefully and if you follow with your transcript, you will hear an amazingly cavalier attitude about the handling of the drug, about its potential diversion onto the streets. It is truly a remarkable conversation. You will hear continued references to the need and the purpose of the clinic as selling Quaaludes to patients. You will hear continued references, or continued responses on the part of the manager, to questions by the physician to the effect, "That is not our problem." The physician asks about the ethics of prescribing Quaalude to a patient who may not need it; the response is, "That is not our problem." He talks about the legality as well as the ethics of the drug being diverted onto the streets, and her response is, "That is not our problem." Throughout, she says, "It is business. This is our business. We are in the business of selling methaqualone."

You will also hear repeated comments to the effect that there is nothing to fear from law enforcement agencies, either State or Federal. The physician asks on a number of occasions what might happen to his license, could he wind up in jail, and the repeated answer is, "No; you have nothing to fear."

I would invite your attention particularly to a comment that appears about halfway into the tape, or about 3½ minutes into it. The physician has talked about the possibility of a patient coming in and misrepresenting his symptoms and then diverting the drug onto the street, and the comment by the manager is this, "Now, if he lies his head off, that is not our problem. If he takes and sells it on the street, it is not our problem." I think that summarizes quite

succinctly the attitude of the people who are managing the stress clinics.

So with that, Senator, if you desire, we will play the tape.

Senator HAWKINS. Please proceed.

[The following is a transcription of the tape played for the committee:]

TRANSCRIPT OF A TELEPHONE CONVERSATION BETWEEN A PHYSICIAN LICENSED IN GEORGIA AND THE MANAGER OF A STRESS CLINIC WHERE THE PHYSICIAN WAS SEEKING EMPLOYMENT. THE TELEPHONE CONVERSATION TOOK PLACE ON OCTOBER 8, 1981 AT 3:00 P. M. THE STRESS CLINIC IS LOCATED IN ATLANTA, GEORGIA. NAMES ARE DELETED FROM THE TAPE.

Manager: Ok. . I have talked to Mr. _____. Mr. _____says that we have the office. We have the operation. Did you get your DEA number?

Doctor: Yeah! I'm going to have it tomorrow, for sure, my DEA number yes.

Doctor: But, what, what you want me to do with the patient when they come in?

Manager: Well, ok, we're a stress clinic like the other stress clinics, like you spoke with Dr., ah, _____, _____, _____.

Doctor: Dr. _____, yeah, Dr. _____, yeah.

Manager: Ok, patients come to us, they talk to us, we prescribe them Quaalude, Valium, ok.

Doctor: Unhuh.

Manager: That's it.

Doctor: That's what you want, they want me to prescribe just Quaalude and Valium?

Manager: If that's what the patient wants. If the patients wants a milder sleeping pill give him something milder.

Doctor: Mmh.

Manager: But I'm saying we have checked with all the other stress clinics and these are medications they use. Dr. _____, uh, is it _____ or _____ ?

Doctor: _____, _____, yes.

Manager: _____, what did he tell you?

Doctor: Well, he say, he talk to give the Quaalude and Valium to each one. To ev, to every patient come, and he say .....nothing against the law.

Manager: Exactly.

Doctor: Ok but, how, how, how I can be protected if, if, in case ah.

Manager: Because they come in and they fill out the forms, and they go through a total psychological examination, evaluation, they go through a brief physical. You spend an hour in psychological evaluation with them. They ca, they can lie their heads off if they want to. That's not our problem.

Doctor: What about if I, I don't want to give the Quaalude and the Valium or some to some kind of patient, you know.

Manager: Then we're going to lose our patient, our money and they are going to another stress clinic, period.

Doctor: That's mean it that its, mandatory to give the Quaalude and the Valium, right?

Manager: Basically yes.

Doctor: Ok, and whac about if the patient looks to me like he going to be a dealing man you know he going to deal in the street?

Manager: That's not our problem.

Doctor: (Unintelligible)

Manager: That's not our problem.

Doctor: What about he's a you know.

Manager: Do you think the other stress clinics are worried about that.

Doctor: Yeah, you have to say something about this, ah, _____. If I make the physical to this patient, and a patient look like that he has been using barbiturates or been using any kind of drug.

Manager: Unhuh.

Doctor: Do I have to give the Quaalude and the Valium, too?

Manager: Yes, if the ah the other stress clinic do it, if we don't they go to another stress clinic.

Doctor: That's means, that's business, right?

Manager: That's business.

Doctor: And Mr. _____ is with this. He, he's agreed with this, because the first time he says no to me.

Manager: Well, I am the person that you are to, you know, converse with, talk with, honestly, plain outspoken.

This is the business we're in, this is the business the other stress clinics are in, and that is it.

Doctor: And that's it.

Manager: And its 100, just about 90% of the people that come in to us will want Quaalude.

Doctor: Unhuh.

Manager: Others will want Valium. And that's, that's the business. If we don't give it to them, hell, all they have to do is go to another stress clinic.

Doctor: Ok, but that, that's a good point, but what about if they catch these people in the street dealing this Quaalude, you understand me.

Manager: That's not your problem and its not our...

Doctor: There is my point, ok how, how, how we going to prove it, that that that I supposed to give just Quaalude and Valium to each, to every patient come in.

Manager: You have made a psychological evaluation this person has cried on your shoulder for an hour and told you all your probl, all his problems.

And you saw probable cause as a doctor for good reason to prescribe this medication. You are, this is what all the stress clinics go on. This guy takes his prescription and sells it on the street. You've got nothing to do with that. He came to you as a patient. You listened to his problems. You talked with him about his problems. You made suggestions for his problems, and you gave him medication.

Doctor: Unh.

Manager: Now, if he lies his head off, that's not our problem. If he takes and sells it on the street, it's not our problem.

Doctor: Do you know one thing I want to be sure is, is he agree with this, you know, that I going to give the Quaalude and the Valium to the people in case the Federal came in. They putting me in jail. Who gonna take me out.

Manager: They can't do that. Look at all the other stress clinics. Look at Dr. _____. He's been doing it for a year or more.

Doctor: Yeah, but look at Florida. They close all the stress clinics in Florida.

Manager: That's Florida. We're running it different in Georgia.

Doctor: I hear, I hear, you see, I hear about doctors. The name, I think, I forget the name, that they put in jail for five years. 5 to 20 years because he was doing this. You know, that was what, what I was afraid, _____, you know, if, if you, you sure that I can have lawyer and everything and no problem with me. I don't wanna lose my license ok I go ahead and do what you want. You know, because in thats way, that don't gonna be my criterio, gonna be your criterio.

Manager: Unhuh.

Doctor: Ok, each, each and every patient come in they want Quaalude, they want Valium, Ok. I want, uh my, I just I just want to, to live here, because I, I don't have a job, you see.

Manager: Right. Ok, if you will accept the concept of this stress clinic, if you will come back to work with us, we'll give you 30% of everything ah, if that's agreeable, Ok. 30% of everything that we bring in, I will talk Mr. _____ into giving you some money because I know you're broke.

And that's my position.

Doctor: Well you, you sure that I don't have problem with the Federal law, right?

Manager: I'm absolutely positive, and

Doctor: And this...

Manager: If Dr. _____can't convince you of it, there's no way I can convince you of it.

Doctor: Ok, and its mandatory me to stay in the clinic have to be Quaalude and Valium?

Manager: Well, if that's, you know, basically what the people need that's what the other stress clinics use for medication. I don't know if you'd call it mandatory but that's what the other stress clinics use, and they've been in legal operation and there's no problem. Dr. _____ told you that, did he not?

Mr. POYTHRESS. Senator, that conversation was made at approximately 3 p.m. on October 8, 1981, which was the period of time in which we were most intensely looking at the stress clinics in Atlanta.

Senator HAWKINS. Was the legislation that evolved after your investigation considered controversial?

Mr. POYTHRESS. At first, we thought that it would be, and in some of our early discussions, we anticipated quite a legislative battle with the legislation. Once it was introduced, we were delighted that the medical community, particularly the Medical Association of Georgia and our own composite State board of medical examiners, heartily endorsed and aggressively supported the legislation. In addition to that, the State board of pharmacy approved it in principle. The amendment to the Georgia Controlled Substances Act was introduced by a physician member of our legislature. So we were surprised that—once it was introduced, there was minimal controversy, and it was supported very strongly by the medical community.

Senator HAWKINS. Do you anticipate that this will eliminate stress clinics?

Mr. POYTHRESS. Not immediately. For one thing, our law had a delayed effective date on it. That was one of the issues we had to come to grips with, the problem of existing inventories of the drug in drugstores. That, in addition to the fact that we in Georgia are now adopting a brandnew code, resulted in a delayed effective date.

Senator HAWKINS. How long was the delay?

Mr. POYTHRESS. About 8 months—until November 1, which is the first date of the new code of Georgia. There were some other legalistic reasons for waiting until the first of November.

I believe that the legislation placing the drug in schedule I is an essential first step in eliminating the so-called stress clinics. This is a drug, in my mind, which had to be dealt with legislatively. I rather suspect that there will be an attempt to use other drugs—Valium, perhaps, or amphetamines. Those drugs are different from Quaalude in a number of particulars. They are not as susceptible to abuse, they are not as attractive for abuse as is Quaalude. Also, we in Georgia, as have the regulatory boards in some other States, have had some success in developing fairly explicit standards of practice, so that abusive handling of those types of drugs can be dealt with under the more traditional methods of licensing boards and criminal prosecution, if need be.

Senator HAWKINS. Do most pharmacies in Georgia stock methaqualone?

Mr. POYTHRESS. As nearly as we could tell, probably a majority do, although they stock it in minimal quantities.

Senator HAWKINS. What would be minimal?

Mr. POYTHRESS. Probably no more than 50 dollars' worth, which would be a minimal supply. Those who had it indicated that they kept it only for the very rare prescription which they got, and in fact, methaqualone is rarely prescribed by most practicing physicians in private practice. The other reason many of the pharmacies do not keep it is because it is such an attractive drug, they were afraid that it would lead to burglaries in their stores. So most of the pharmacies kept either little or none of the drug. The pharma-

cies who kept large quantities of it were the pharmacies who were filling the prescriptions from the clinics.

Senator HAWKINS. Did the pharmaceutical industry in Georgia respond formally to the State legislature?

Mr. POYTHRESS. The State board of pharmacy endorsed in principle the idea. They did not formally endorse it, nor did the pharmaceutical association. However, the Pharmaceutical Association of Georgia did help us politically in passing the bill.

Senator HAWKINS. I know you are an attorney and have handled medical board cases before. Could you explain to the subcommittee—other members will read this, of course—some of the difficulties associated with bringing criminal and civil actions against physicians?

Mr. POYTHRESS. Well, I think the problem stems basically from the fact that you are dealing with a profession which, by definition, embraces an extremely broad expanse of judgmental and discretionary activities. By definition, you cannot write on a tablet how to practice medicine. Much of it must be judgments by the individual physician, based on the facts of an individual case.

In order to secure the best practice of medicine, that scope of discretion must remain broad. They must have the judgment to deal with individual problems. The question then becomes what is bad medicine as opposed to what is bad faith.

Second, dealing with this particular drug is one that is almost impossible to deal with using undercover agents. If an agent presents at a clinic, claiming that he has trouble sleeping, the physician does a psychological and a physical and prescribes the drug—once again, he has touched all the bases. And his response to a charge of misconduct is, "I simply believed what the patient told me." That is somewhat different from other types of drugs, for example, amphetamines, frequently used for weight control. If an undercover agent, 21 years old, who weighs 115 pounds, goes in complaining of being overweight, and a physician prescribes amphetamine, you have got a pretty clear-cut case of inappropriate prescribing.

I think basically, it boils down to the question of maintaining in the practice of medicine the broadest possible discretion, as well as protecting, as a general principle, the procedural rights and the due process rights of people in a free society. Given those problems in prosecuting individual cases, it was our judgment in Georgia that the best approach to dealing with Quaaludes was legislative, to put them basically off the market.

Senator HAWKINS. And how will that apply to stress clinic cases?

Mr. POYTHRESS. Well, as I indicated earlier on, it will be a first step, we hope, in eliminating and closing them down. They will no longer have their prime product, which is Quaalude.

Senator HAWKINS. What is your personal opinion of legislation that accomplishes on a national level what your law does in Georgia?

Mr. POYTHRESS. I think it is not only appropriate, I think it is essential, and I think it is absolutely necessary. This is not just a Georgia problem, it is not just a Florida problem. It is a national problem, in your words, of epidemic proportion. Not only is there the problem of spillover of one State to another, in terms of the

prescribing of the drug, but we in Georgia, for example, have concluded that unless other States likewise ban Quaaludes, or unless it is banned nationally, a properly labelled prescription bottle from another State becomes a license to possess in Georgia the amount of drugs that is prescribed to be inside. It does not take a lot of thought to see how that could be a very serious problem which would basically facilitate continuation of the business of dealing in Quaaludes. All you would need was a container that was properly prescribed in another State.

Senator HAWKINS. Mr. Poythress, you and Mr. Fowler are both to be commended for taking what I consider to be an aggressive posture in eliminating this problem. If other States would join hands and do that, maybe the Federal Government would not have to. In the absence of that, I think that we will find that at least those Senators who are members of the Drug Abuse Caucus will embrace this aggressive attitude. I think it is ironic that while we are debating the defense bill on the floor that we are talking about the war against drugs here. In many ways it should be our first line of defense for a successful America. I congratulate you both for the jobs you have done so well in Georgia.

Mr. POYTHRESS. Thank you, Senator.

Senator HAWKINS. Thank you both.

Our next witness will be Dr. Swartzburg, who is an associate professor of psychiatry at Rutgers Medical School in New Jersey. We thank you very much for being patient and for being with us today. I understand you have a brief statement.

Dr. SWARTZBURG. Yes, Senator. I am currently associate professor of psychiatry at Rutgers Medical School. My career in psychiatry has been in clinic psychiatry, first at Yale Medical School and currently at Rutgers Medical School. During this time, I have served as director of in-patient crisis intervention, emergency services, and as chief of adult services at Rutgers Medical School. My particular area of specialty interest has been in the area of anxiety, depression, sleep, and I publish in these areas, both here and abroad, including in 1973 one of the first reports documenting the fact that methaqualone is indeed an addictive drug. Prior to that time, it was considered to be a nonaddicting drug. It was this evidence that led to its initial placement on the schedule of controlled drugs in 1973.

Just recently, I have served as an expert witness for the State of New Jersey in the criminal prosecution of the staff of a stress clinic operating in northern New Jersey in close proximity to New York City. That case, I believe, has just gone to the jury, either yesterday afternoon or this morning. We still await the results as to whether or not there will be a successful criminal prosecution in this case.

This case was a bit unusual in that among the staff who were being prosecuted were two physicians. Because of the medical aspects of the case, I found myself as an expert witness, on the witness stand for 6 days, which gives some idea of the complexity when you begin to try and prove bad faith as opposed to bad medicine.

Senator HAWKINS. In your professional opinion, how broad are the medical uses of this drug?

Dr. SWARTZBURG. Very limited, Senator. Methaqualone is a drug belonging to the general class of hypnotic sedatives—that is, it is a sleeping pill. Prior to the advent of specific antianxiety drugs, antidepressant drugs, antipsychotic drugs, all we had available back in the early sixties were sedatives. This is no longer the case. So methaqualone has very limited use, if any use at all, as a sedative. Its primary use is as a sleeping pill. And as a sleeping pill, it is one of many sleeping pills. Today, we realize that there are many forms of insomnia, and that in most cases, sleeping pills are not the answer. We are far more aware that people develop tolerance to sleeping pills, that they very seldom will remain effective after 7 to 14 days—30 days at the most for some of the sleeping pills. As a sleeping pill, methaqualone offers no unique advantages that are not present in other sleeping pills. So it is a drug which has no specialized or unique advantages, and it is now within the general practice of medicine very, very seldom prescribed.

Senator HAWKINS. What is it about the drug that makes it so attractive to teenagers and young adults?

Dr. SWARTZBURG. Well, any sedative and hypnotic tends to work via different pathways within the brain, so they all have a very unique effect. What makes methaqualone popular is that it produces a rather unique experience, a kind of euphoric dissociative high, that many will say is closest to the kind of heroin high if they have used heroin in the past.

Second, if someone is not tolerant to methaqualone and they take a good amount of it, they may get a feeling which is known as "the buzz"; much as one might talk about the heroin "rush" is the methaqualone "buzz," which is kind of a tingling, euphoric sensation that many people have considered to have an aphrodisiac quality to it.

In addition to that, the drug mixes with alcohol, and unfortunately, what happens is that the effects of alcohol will sum with the effects of methaqualone, and alcohol also has the effect of raising the blood levels of methaqualone, so you get kind of a "double whammy" when you mix it with alcohol.

This drug, as people have said, can be used either straight or mixed. It is mixed with alcohol, oftentimes because alcohol can increase the effect of a limited amount of methaqualone, and it is also used in combination with stimulant drugs such as cocaine. The idea is to "mellow out" the cocaine experience.

In addition, the drug has had a tremendous press amongst young adults and teenagers. It has been considered to be the "love drug," to have aphrodisiac properties. It is popular in the disco scene, which accounts for its nickname, "Disco Biscuits." And what generally tends to happen is that it begins with young adults at the college age, and then the teenagers very quickly pick it up from their older siblings.

Senator HAWKINS. In your opinion, why did stress clinics pop up?

Dr. SWARTZBURG. Stress clinics popped up, I think, particularly to service a particular group of people. In the 800 charts that I reviewed in connection with the trial, most of these people were white collar, young, professional individuals. The advantages of the stress clinics to these individuals is that it allows them a legitimate source of methaqualone. They are a little bit wary of buying it on

the street, because they may get adulterated substances; they may get their money ripped off; or, they may find themselves in legal difficulty. So that they have the finances to come to these particular stress clinics, and these stress clinics have a very large market. If you can get one of these clinics going, the phones virtually ring off the hook with people trying to make appointments to these clinics for this advantage.

Also, even if one is paying $125 for 45 Quaaludes, it is an economic advantage because even with the cost of the drug at the pharmacy, it is still cheaper than buying it on the street, and you are getting a legitimate prescription and the real drug. So there is a real market for these types of clinics.

Now, why the physicians get involved is a simple word: money. They are incredibly profitable. With a rather small operation, seeing no more than four patients an hour, with two part-time doctors, one could calculate out that the operator of a clinic would make about $300 an hour—that is profit, after everyone has been paid. And it depends on how much business he has, but that is on a very small operation, touching all the bases of doing the physicals and some lab work and everything else, to make it look respectabl. It is incredibly profitable.

Senator HAWKINS. How do they diagnose stress in these clinics?

Dr. SWARTZBURG. Well, stress is not a medical diagnosis. What is a medical diagnosis is the human's reaction to stress. Someone may have insomnia, they may have a specific anxiety disorder, they may have depression. So stress clinics like to stay away from these sorts of specific diagnoses, because they would almost demand another treatment. Stress is a general term. Almost anything is a stress—a hot day, bad traffic. Some of the stresses that were reported in the clinic I saw were high interest rates, and this was in one case justification to keep somebody on 8 months of methaqualone because of the effect of interest rates on his business. Getting married was considered a stress. They gave one young man enough methaqualone to keep him asleep for a month, 2 days before his supposed wedding.

Senator HAWKINS. When was the divorce?

Dr. SWARTZBURG. We do not know whether the wedding actually took place. Some of the stories on the charts did not correspond to the statements of witnesses, obviously, at the trial.

So, since anything is a stress, and since stress can cause anxiety and insomnia, almost anybody qualifies for methaqualone. And the less differentiated the diagnosis, the less the demand for a specific type of treatment other than methaqualone.

Senator HAWKINS. You have heard Mr. Poythress here today tell what they have done in Georgia; Florida has followed suit. We have introduced legislation, as you are aware, nationally. Do you think prohibiting the prescription of Quaaludes will have an impact on the problem we are discussing today?

Dr. SWARTZBURG. Yes, I think it will, and I think in a number of areas. It will certainly put the stress clinics out of business in the prescription of methaqualone. And, while 90 percent of it is illegally imported methaqualone, and this legislation will not directly affect that, I have another concern, and that is the concern as a physician I feel for medicine. These clinics really foul the nest of

medicine. And as I have been talking to physicians whose instinctive response has been, "Well, we are concerned about legislative controls of medicine," I have spoken to them of what I have seen at this particular clinic, and their response immediately changed. I mean, this just simply has to stop.

After an involvement in a 4-month trial, I am acutely aware of how difficult it is, costly, and even uncertain, to put these clinics out of business via that route.

I also, coming from a metropolitan area, have some concerns about action on the part of individual States, because in New Jersey, we would need legislation in Connecticut, New York, Delaware, Pennsylvania, and New Jersey, to cut down on the market.

I see the only solution as national legislation. And we are not losing a unique drug that we need in the practice of medicine. If methaqualone were coming up today for approval, and we knew what we know about it now, if you consider the automobile accidents, the abuse, the overdoses, the withdrawal seizures as part of the side effect profile of methaqualone, then clearly, such a drug would not be approved. What happens is these things are considered to be indirect effects, that is, the drug taken as prescribed will not cause these effects. But methaqualone abuse is not new. We had a huge epidemic of it between 1968 and 1972, which led to the original legislation. If you looked into the matter, England had had the same experience even earlier. The same thing was in the Japanese literature.

Methaqualone will produce a high level of abuse. We have now had almost 15 years of repeated evidence of this. We know it is going to be abused. And if it is going to be abused, we are going to have the auto fatalities, we are going to have the overdoses, we are going to have withdrawal seizures, and the sum total of the medical benefit of th[illegible]ug is virtually negligible, compared to the harm that it currently [illegible]oduces.

Senator HAWKINS. Thank you so much, Dr. Swartzburg. We appreciate the testimony of the entire panel. We will excuse you at this time.

Dr. SWARTZBURG. Thank you.

Senator HAWKINS. For our final panel of witnesses, I would like to introduce Mr. Stewart Turley, who is chairman of the board of Jack Eckerd Corp. from Clearwater, Fla., and Dr. Charles Wetli, the Dade County Deputy Chief Medical Examiner in Miami. Mike Zagorac, vice president of the company, is accompanying Mr. Turley. Welcome.

Mr. Turley, we will start with you. I understand you have a statement.

STATEMENT OF STEWART TURLEY, CHAIRMAN OF THE BOARD, JACK ECKERD CORP., CLEARWATER, FLA., ACCOMPANIED BY MIKE ZAGORAC; AND DR. CHARLES WETLI, DADE COUNTY DEPUTY CHIEF MEDICAL EXAMINER, MIAMI, FLA.

Mr. TURLEY. Thank you very much, Madam Chairman and members of the committee. I am Stewart Turley, chairman of the board and president of the Jack Eckerd Corp.

Our principal subsidiary is the Eckerd Drug Co., which operates 1,221 drugstores in 16 States. Our pharmacies operate in all areas of the Sun Belt from Texas and Oklahoma through the South and up the eastern seaboard into Maryland, Delaware, and New Jersey.

In 1981, our company was the Nation's largest private provider of prescriptions to the American public.

Over the years, our company and our pharmacists have supported both public and governmental efforts to better inform the public on health care and the proper use of drugs and prescription medications. Likewise, we have been deeply involved in community, private and governmental efforts aimed at curbing the misuse and abuse of drugs.

Late last year, the growing abuse of the drug methaqualone was discussed within our organization. Upon further study, it became apparent that this drug, which does have a legitimate medical use, was being severely abused all across the Nation and including many of the major metropolitan areas in which our company operates.

Further research on this drug, its medical history, comments from our pharmacists and input from physicians and other health practitioners clearly indicated that this drug was considered a serious problem and that there were several alternative products available for the same medical purposes that are much less dangerous.

On January 12, 1982, we stopped stocking methaqualone in our pharmacies in all States in which we operate. In taking this action, we hoped to bring additional public attention to the serious abuse problem regarding methaqualone. At the same time, we sent communications to the Federal Drug Enforcement Administration, the State drug enforcement agencies, and the various State pharmacy and medical boards, advising them of our action and urging them to support regulation or legislation that would reclassify methaqualone, making it illegal to stock or dispense the drug at any pharmacy.

It is fair to say that as legal prescriptions for the drug methaqualone were steadily diminishing, its abuse steadily increased. Since there were other therapeutic drug products available for the same medical purpose, we believed that the value of its therapeutic effectiveness was overshadowed by its growing abuse.

Fortunately, public, governmental, and health provider response has overwhelmingly supported our action. And, as you have heard this morning, two States—Florida and Georgia—have enacted legislation which effectively prohibits the legitimate dispensing of methaqualone in those States. With similar legislation pending in several other States and the recently introduced legislation by the chairman of this committee, we believe that our action was appropriate and that legislation prohibiting its manufacture and distribution will be effective in reducing the abuse of the drug methaqualone in our Nation.

Senator HAWKINS. Thank you, Mr. Turley. We really appreciate the leadership that you have shown as a prominent businessman in helping bring about the curbing of the abuse of this drug.

Is it a widely accepted and readily available prescription drug in U.S. pharmacies?

Mr. TURLEY. Yes, Senator, it is. However, we are aware that most pharmacies, in fact, have reduced their inventories of methaqualone, and in fact, that fewer prescriptions were being written every day for the legitimate medical use of the product.

Second, many pharmacists reduced their inventory in that drug simply to attempt to alleviate the problems with thefts and burglaries.

Senator HAWKINS. Do you stock other drugs which have a similar application?

Mr. TURLEY. Yes; we certainly do, and this is one of the primary reasons where we felt our action was not in conflict with the interest of the medical community. There are many very good alternative drugs for the same therapeutic purpose, and they are readily known to all of the physicians who are legitimately prescribing for problems that they might be using methaqualone for.

Senator HAWKINS. It is my understanding that your corporation has been active in other States besides Georgia and Florida, in encouraging legislatures to reduce the availability of methaqualone; is that accurate?

Mr. TURLEY. That is true. We have been working with many States, and in fact, there is legislation pending in four other States besides Florida and Georgia who have completed their legislative efforts in this regard.

Senator HAWKINS. I believe you were in the room and heard Dr. Swartzburg tell why he feels Federal legislation would make a significant contribution in this area. Do you agree with that? What do you feel about national legislation?

Mr. TURLEY. We are very supportive of your efforts and this Federal legislative process. We think this is a unique situation, requiring unique action, due to the extremely high abuse level of this particular product, the fact that there is a low legitimate prescription activity for this product, and that there are very good alternative products available for the medical community to prescribe.

Senator HAWKINS. Do you put a sticker or a notice on the window of the pharmacy or the door to the store indicating that you do not stock this? How do you notify the public?

Mr. TURLEY. We have notified the public, but we have not done it through putting signs on the fronts of our stores. Perhaps we should consider that, however, because of the terrible problem we and other retail pharmacy operators have had as a result of armed robberies and thefts within our stores. As a matter of fact, one of the leading drug publications last year did a study which indicated that over 100 pharmacists had been killed in their stores during armed robberies in the past 2 or 3 years. It is a very serious problem. We and other drugstore operators have attempted to focus attention on this growing problem. Some action has been taken in this regard, but not nearly enough. We are concerned about the safety of our employees, our pharmacists, and our customers. And while our primary purpose in taking the action that we took with methaqualone was to focus attention on the terrible problem that is a national epidemic, certainly, a secondary purpose was to perhaps reduce the temptation of that armed robber or thief to come into our stores.

I might mention that 45 percent of the armed robberies in our stores in the last couple of years have been committed for the purpose of taking drugs from the prescription department, as opposed to money or merchandise alone.

Senator HAWKINS. Well, I commend you again for the action that you have taken. I am aware of it and have discussed your efforts with other drugstore operators. They want the protection in some instances, but they also want the profits that come with selling the drug. And since you have indicated—and other doctors here today have indicated—that there are alternative drugs available, I do not believe you have deprived anyone of anything and have helped, as you have stated, protect the lives of your employees. It may be helpful to put a notice someplace for those who do not know of your policy.

We commend you for your efforts.

Dr. Charles Wetli is with us today. He is the medical examiner in Miami. I understand you have a short statement.

Dr. WETLI. Yes, Senator.

I am the deputy chief medical examiner for Dade County, Fla., and an assistant professor of clinical pathology at the University of Miami School of Medicine.

As a medical examiner and forensic pathologist, my main job is to investigate any death which appears to be suspicious for other than natural, or the death of anybody who dies suddenly or unexpectedly when they are apparently in good health.

Over the past several years, we noticed an apparent increase in the methaqualone-related deaths occurring in Dade County, which of course encompasses the Greater Miami area. Our current population base is about 1.7 million people.

The results of the survey which I performed indicated that from 1971 through and including 1981, we had 246 deaths related to the use of methaqualone. The chart I have here demonstrates that. The increase we have seen first occurred in 1973, when we had a peak of about 17 deaths. These were almost always overdose deaths. This was occurring at a time when the drug was relatively cheap and easily obtained by legal prescription and easily procured from a legitimate pharmacy. The rescheduling of the drug and greater awareness on the part of the medical community of its abuse potential resulted in a dropoff of methaqualone-related deaths. In 1978, however, we saw a fantastic increase in methaqualone-related deaths, and it has been gradually increasing rather sharply, and in 1981, we had 70 deaths alone attributed to the use of methaqualone.

Now, as opposed to the situation we had in 1973, deaths since 1978—which, by the way, is 76 percent of this series altogether—deaths since 1978 are related to trauma. We are seeing again an increase in overdose deaths but not nearly as severe as in 1973. I think the reason for this is because currently, the drug sells for $3 to $5 a pill on the streets in Dade, and it is not the situation where a person is going to have a bottle of 50 or 100 sitting on their shelf.

The current methaqualone-related death we are seeing today is in a 23-year-old white male who gets killed while driving an automobile. We do see deaths from other things, such as falling out of trees, drowning and so forth, but this seems to be the actual pat-

tern which we are encountering today with regard to methaqualone.

As Dr. Swartzburg mentioned in earlier testimony, the typical pattern is also one of mixing methaqualone with alcohol. Our studies, however, indicate that these people generally have less than intoxicating amounts of alcohol present when they die.

The racial distribution is such that it is not a popular drug among blacks for the most part, but predominantly white males are using the drug, and 70 percent of our series were white males, and 26 percent white females.

Senator HAWKINS. So are you telling us that even a very small amount of alcohol can multiply the effect of Quaalude?

Dr. WETLI. Yes, Senator. This is a phenomenon we know in medicine as synergism. The easiest way to explain it is that two plus two equals six. A low level of one drug plus a low level of another drug gives you a greater than additive effect.

Senator HAWKINS. Among those who died in Dade County in 1981 from Quaaludes were a number of drowning victims who knew how to swim. Why would that happen?

Dr. WETLI. Our studies indicate that methaqualone acts very much like alcohol upon the central nervous system, whether or not alcohol is present. Much like the drunk individual, the individual who tries to swim under the influence of methaqualone is essentially less competent to cope with a relatively benign environment. As a result, they are somewhat anesthetized already, and then inhalation of a small amount of water, lack of physical endurance, and so forth, can result in drowning.

Senator HAWKINS. You say in your study that a drug should be considered on the basis of three criteria: The potential for overdose, the way it modifies behavior, and consequences of prolonged use. How do you evaluate methaqualone based on these three factors?

Dr. WETLI. First of all, we know that there is a tremendous potential for recreational and suicidal drug overdoses under the influence of methaqualone. We have seen that most poignantly in the early 1970's, when the drug was much more available in larger quantities and relatively cheap. Should this happen again—in other words, we have a tremendous amount of drug available at a low cost—it is, I think, rather reasonable to anticipate that we will have increases, in overdose deaths, particularly accidental overdose deaths related to methaqualone.

The biggest problem we have today socially, economically and medically, from the use of methaqualone—at least, the recreational use of methaqualone—is where it modifies human behavior such that a person can no longer cope with a relatively benign environment. This is why we are seeing tremendous increases in single-vehicle crashes, killing the driver of an automobile and perhaps killing other people, as well. And this is, I think, the greatest hazard about methaqualone today.

What my study cannot tell is how many innocent people are getting killed or injured by an individual under the influence of methaqualone who nonetheless survives the automobile crash. We know it happens, and we know the potential is there, but we have no way of actually identifying it. Because of the medical examiner

system, we must rely on the identification of the drug in the victim.

The third factor is the consequences of prolonged use. We have not seen anything so far to indicate that there would be any damage from this. For example, autopsy findings are not typical, as you might find, say, in an alcoholic or a heroin addict, where you do find very specific things to indicate abuse of those substances. So far, if we do an autopsy on somebody, we cannot tell if they are using methaqualone or not, but that is about as far as we can go. But it might also mean we have not had quite enough experience with it. It is very hard to say at this point.

Senator HAWKINS. I understand from the testimony today and some of our studies that many of the Quaaludes processed in the clandestine laboratories are not pure methaqualone. Are there any special dangers associated with the use of the black market Quaalude?

Dr. WETLI. There are tremendous dangers, or at least potential dangers, with it. In the medical literature, it has been reported that drugs sold as Quaaludes or Lemmon-714's have in fact contained no methaqualone at all, but have contained phencyclidine, known on the street as "Angel Dust," which is an hallucinogenic-type drug, causing frequently bizarre behavior and so forth. We have seen samples of methaqualone, or apparent methaqualone tablets, which contain only diazepam, more commonly known as Valium. The typical thing, however, is we find the counterfeit tablets will contain a mixture of methaqualone, diazepam or Valium, and usually phenobarbital. Again, you are going to have the same problem of synergism with these drugs as you would with alcohol, depending on the amount that are in the tablets themselves.

Senator HAWKINS. In your view, are there safe alternative sedatives on the market?

Dr. WETLI. Yes, I believe there are safe alternative sedatives on the market. There are a variety of drugs, ranging from chlorohydrate to the barbiturates and so forth, both for tranquilizing and for hypnotic effects.

Senator HAWKINS. Is there any evidence to suggest that methaqualone may make the user react violently and irrationally?

Dr. WETLI. Yes. We have seen, for example, an increase in traumatic suicides. By traumatic suicide, I mean where somebody shot himself in the head or hanged himself while under the influence of methaqualone. In our series, one-third of our traumatic suicide victims did so on an impulsive nature during the course of an altercation. For example, boy friend and girl friend having an argument, one runs into the bedroom, grabs a gun, and shoots himself—a very impulsive type behavior.

In the homicide victims we have seen that approximately one-third were judged to be justifiable homicides, mainly a person committing a felony and being shot by a citizen or police. This means one-third of the methaqualone-related homicides fall into a justifiable homicide, which is certainly not what we see in the overall homicide rate in Dade County, where less than 5 percent would fall into that category. It would indicate, probably, lack of judgment and a propensity toward violence in both categories, the suicide and the homicidal victims that we have seen.

Senator HAWKINS. Your study recommends that appropriate governmental action be taken to curtail the recreational use of Quaaludes. Would Federal legislation banning the prescription of Quaaludes be helpful?

Dr. WETLI. Yes, I believe it would. It is frequently pointed out that we see the problem in Dade County, but it is sometimes not seen in other places, and I do not believe that is true. For example, a news reporter called me recently and said, "We have got an awful lot of Quaaludes being prescribed in this particular city, but nobody seems to think that there is any death on the highways related to it." Well, investigation showed that they do not investigate deaths the same way we do, and their law indicates they can only test for alcohol. If you can only test for alcohol, you are never going to find methaqualone.

I think the studies and the data obtained from Dade County, Fla., and from New York and other cities, where there is methaqualone available on the streets and where we can identify the deaths from it indicates that it is just not really localized to those areas. Other places may not have the ability to identify these things, but I think as long as the drug is there we are going to see abuse of it, and if you are going to see abuse of it you are going to see death and nonfatal injury resulting from it.

So on that basis, I think that Federal legislation would certainly be quite helpful in controlling the distribution of this drug with a high abuse potential.

Senator HAWKINS. Thank you so much, Doctor.

We want to assure all of you who have participated on our panels today that this record will be distributed to the members of the Senate Drug Caucus and will be most helpful in garnering the support that we need for the Federal legislation. The testimony you heard today is dramatic evidence of a unique type of drug epidemic that must be faced and defeated. The numbers are staggering both in terms of the persons affected and the quantities of drugs being distributed. Methaqualone now has a history of easy availability and alarming consequences.

Of particular concern to me is its use among young people. Unfortunately, we now have a generation who have learned to use different varieties of drugs as an answer to their own personal problems. For many, it is a way of life, and I think we must increase our efforts to turn the orientation of this society away from a drug solution. Legislation will play a role in the process by making it illegal to prescribe or distribute methaqualone. We can at least put a stop to the stress clinics as a source of drug distribution. In so doing, we can send a message to our young people that this is not accepted or safe as a form of recreation or entertainment.

Law enforcement has been, and always will be the key in our efforts to control the distribution of controlled substances. I can assure you that this subcommittee and the Senate Drug Caucus will continue to support the efforts of the Drug Enforcement Administration and State and local police. Through continued cooperation and assistance from the people, the courts and the Congress, we can look forward to a society less dependent on the drug culture. We must begin our work now.

Thank you so much for your participation.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

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